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ABSTRACT

This document contains a preliminary report on the implementation of Wisconsin's Community Options Program (COP), a program designed both to divert persons from entering nursing homes and to deinstitutionalize current nursing home residents who can be effectively served by community-based alternatives. The introduction of this report provides a description of the program and information on the eight counties which are operating programs, funding, and methods used to prepare the report. Part I of this report focuses on the policies and procedures developed in each of the volunteer counties and on county staff and community representatives' opinions regarding program operations. Information on program context, operations, indirect effects, and agency assessment of initial implementation is presented for each county individually. The section concludes with a summary of programs in the eight counties. Part II evaluates COP county efforts to target program services to the type of clients described in the legislation and guidelines for the program, and describes the type, amount, and cost of services provided to clients in the initial months of program operation. Also presented are findings from two client telephone surveys conducted to determine why some clients preferred nursing home care to community services and to assess client satisfaction with COP assessments and community services. Part III contains conclusions and recommendations focusing on future implementation of COPs. A bibliography and 63 data tables are included. Appendices include data collection instruments, statutory language, summaries of other community options programs, level of care definitions, and community services definitions. (NRB)

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THE COMMUNITY OPTIONS PROGRAM:

An Evaluation of Early Implementation Experience

Division of Policy and Budget

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Wisconsin Department of Health and Social Services

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Madison, Wisconsin

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THE COMMUNITY OPTIONS PROGRAM:

An Evaluation of Early Implementation Experience

Wisconsin Department of Health & Social Services
Division of Policy and Budget
Bureau of Evaluation

January, 1983

PREFACE

Section 2020(9) of Chapter 20, Laws of 1981, required the Department of Health and Social Services to submit an evaluation of the Community Options Program to the governor and the presiding officer of each house of the legislature by January 1, 1983 — one year after the program was initiated. This report is submitted in response to that requirement and also to provide information that will be of use to the counties initiating programs in 1983.

The report evaluates the alternatives to nursing homes offered to the residents of the eight Wisconsin counties which volunteered to operate Community Options Programs in 1982. It reflects program activities through September 30th of that year and is a preliminary report on the start-up period of these programs. Because it was not possible to obtain adequate data on the fiscal effect of these programs by the time this report had to be prepared, a second report focusing on the cost-effectiveness of the programs is scheduled for publication in December of 1983.

The findings presented in this report are drawn from reports submitted to the Department of Health and Social Services by volunteer counties; on-site interviews of county staff and community representatives; telephone surveys of clients who were assessed by the program; patient records from the Division of Health's Bureau of Quality Compliance, which is responsible for licensing and certifying nursing homes in the state; and data from the Department's Medicaid Management Information System.

Questions about the report should be directed to Bob Wagner, Director, Bureau of Evaluation, Division of Policy and Budget.

DOCUMENT DIGEST

Department of Health and Social Services

Document Title: The Community Options Program: An Evaluation of Early Implementation Experience

Document Date: January 1983

This report describes and evaluates the early implementation of Community Options Programs (COPs) in the eight counties which were selected to operate programs in 1982. The report is based on program operations through September 30th. Findings are drawn from reports submitted to the Department of Health and Social Services by volunteer counties, on-site interviews of county staff and community representatives, telephone surveys of clients who were assessed, patient records from the Division of Health's Bureau of Quality Compliance, and data from the Department's Medicaid Management Information System.

Part I of the report focuses on the policies and procedures developed to implement programs in each of the volunteer counties and on county staff and community representatives' opinions regarding the operation of the program.

Part II of the report evaluates COP county efforts to target program services to the type of clients described in the legislation and guidelines for the program; describes the type, amount, and cost of services provided to clients in the initial months of program operation; and presents findings from two client telephone surveys. (One of the surveys was conducted to determine why some of the clients assessed, or their guardians, preferred nursing home care to community services. The second survey was conducted to assess client satisfaction with COP assessments and community services.) The report also includes a number of recommendations focusing on future implementation of Community Options Programs. Conclusions and recommendations are presented in part III of the report.

A summary of findings from the report follows.

Program Operation

By September 30th, the number of months Community Options Programs had actually operated ranged from two months to eight months per county.

Referrals

- The plans counties adopted to phase-in COP referrals from various sources (such as nursing homes, hospitals and the community) varied considerably in complexity and were not always strictly followed in processing initial referrals to the program. Two of the eight counties found it necessary to revise their initial phase-in plans in order to obtain more referrals.

- By September 30th, 592 persons had been referred to Community Options Programs in the 8 counties and 65 percent of these persons had been assessed.

- It was estimated that COP counties would assess less than 1,000 persons by the end of 1982.

- The most frequent reasons for not assessing clients referred were that the client waived the assessment or was not in the target group.

- Several of the counties adopted client eligibility criteria in addition to those in the eligibility definition presented in the state guidelines for the program. Two of the counties reported that they found it necessary to revise locally adopted criteria for client eligibility and several noted that trying to clarify who was eligible for the program was one of the more difficult aspects of initial implementation.

- Slightly over half (51 percent) of the persons referred were in a hospital when referred; approximately 40 percent were in community settings; and the remaining 9 percent were in a nursing home or DD center.

Assessment

- Only one of the counties was highly satisfied with the assessment process they adopted initially. Five of the eight counties reported that their assessment process had been revised during the initial months of program operation.

- The client telephone survey indicated that clients were generally satisifed with the assessment process; although some clients objected to the personal nature of some of the questions they were asked.

- By September 30th, COP counties had assessed 384 persons. The average age of the persons assessed was 76 years. Data reported for 65 percent of the persons assessed suggested 74 percent needed skilled (SNF) or intermediate ICF-1 care. The remaining clients were evaluated as needing intermediate ICF-2 (14 percent), ICF-3 (10 percent), ICF-4 (1 percent) or less than ICF-4 (less than 1 percent) care.

- Only 48 percent of 100 clients assessed through May were found to be eligible to have Medicaid pay for part of the assessment cost. This was less than the 67 percent expected to be so eligible.

- Case plans were developed for 42 percent of the clients assessed.

- The most frequently reported reason for not developing a case plan for a client assessed was that the person was going to enter a nursing home because the person or the person's guardian preferred nursing home care.

- A telephone survey to a sample of the clients and guardians who reportedly preferred nursing home care showed that in most cases there was more than one reason for deciding to enter a nursing home. Eighty-six percent of the respondents cited more than one reason. The most frequent reasons were that a doctor wanted the person to enter (84 percent), a family member wanted the person to enter (76 percent) and the person felt she/he needed the services offered in a nursing home (71 percent).

- The survey also showed that the decision to enter a nursing home was often based on the urging of other persons. Only 10 percent of the respondents reported that the decision to enter the nursing home was not partially due to the urging of other persons.

Case Plans

- Almost all of the case plans that were developed were implemented or scheduled to be implemented.

- In the few cases when case plans were not implemented, the reason was usually that the person preferred nursing home care or had to be hospitalized.

Service Clients

- By September 30th, 140 of the persons assessed by Community Options Programs had been provided community services. Ninety-two of these persons received services that were at least in part funded with COP dollars.

- Sixty-two percent of the persons who received community services were estimated to need skilled (SNF) or intermediate (ICF-1) care, but a third of the 50 clients receiving COP-funded services who were surveyed reported that nursing home care was never seriously considered. Another 10 percent said they did not think nursing home care had ever been seriously considered but noted that someone else (doctor or relative) may have considered it.

- The average age of the clients receiving community services was 74 years; 61 percent were female; 50 percent were widowed; and 68 percent were elderly persons without categorical disabilities such as drug abuse or developmental disabilities.

- Only 6 of the 140 clients receiving community services were in a nursing home when they were assessed.

- By September 30th, 23 of the 92 clients receiving COP-funded services had been terminated from COP caseloads. Seventy percent of these clients were dropped from the program because they entered a nursing home or died.

Services Provided

- By September 30th, persons receiving COP-funded services had received an average of 65.9 days of service per client.

- Clients received an average of four different services including case management. The most common use of COP funds was to provide supportive home care.

- County staff generally felt that they had been able to obtain adequate services and living arrangements for the clients served and a survey of 50 of the clients receiving COP services showed that almost all of them were satisfied with the type, amount, and quality of services provided.

- Only one of the eight counties reported that new community services were developed as a result of COP and only two of the eight counties noted that existing community services had been expanded as a result of COP.

Cost of Services

- Counties reported spending $56,043 of COP service funds by September 30th. This amount represented approximately 20 percent of the COP service allocation adjusted to reflect the months of actual program operation in each of the counties.

- Only three of the eight counties established ceilings for the amount of COP service dollars that could be spent per client per month.

- It was estimated that the $56,043 COP service dollars actually spent averaged $11.51 per client per day of service which would be $349.90 per month. This was under the monthly guideline of $400 per client per month selected to represent the state share of nursing home costs for Medicaid clients.

Funding Sources

- In addition to COP service dollars, other funding sources used to provide community services included client fees and public funding sources such as Title 20 of the Social Security Act.

- Some clients receiving COP-funded services or services funded from other public sources were charged a fee to pay part or all of the cost of these services. The assessment of client fees depended upon client income and assets and county policies.

- Counties adopted a variety of policies to determine what funding sources would be used to pay for the non-client share of community services. The type of policy often varied by the type of client being served (clients new to the lead agency versus those previously on the lead agency's caseload) as well as by the type of alternative funding source being considered.

Coordination With Medical Staff

- Only three of the eight counties reported that they had good to adequate communication with hospital staff, nursing home staff and physicians in the initial months of program operation. Specific problems noted were difficulties in scheduling as well as adequately assessing hospital clients, and that physicians were not referring clients to the programs, were not adequately aware of the program and/or tended to prefer nursing home care for their patients.

Effects on Lead Agencies

- County staff reported that while initiating the Community Options Program had increased the workload in their agencies, it also had led to a greater awareness of the target group and of the community resources available to serve these persons.

- Staff from only one of the eight lead agencies reported that initiating the program had led to any changes in their agency's policies or procedures.

TABLE OF CONTENTS

PREFACE

Page

Chapter

I. INTRODUCTION 1

Program Description 1
Counties Volunteering To Operate Programs 9
Funding 14
Methods Used To Prepare This Report 20

PART I. DESCRIPTION OF COUNTY PROGRAMS 25

II. Dane County 27

III. La Crosse County 42

IV. Pepin County 56

V. Portage County 67

VI. Racine County 85

VII. Rusk County 102

VIII. Waupaca County 112

IX. Winnebago County 129

X. Summary 141

PART II. PRELIMINARY EVALUATION FINDINGS 149

XI. Targeting 150

XII. Services Provided 169

XIII. Client Surveys 177

Why Do Some Clients Turn Down Services? 179
Are Clients Satisfied With The Services Provided? 185
Are Clients Satisfied With COP Assessments? 194

XIV. Summary 197

PART III. CONCLUSIONS AND RECOMMENDATIONS 204

Page

REFERENCES 212

APPENDICES 214

A. Data Collection Instruments 214

County Reporting Forms 214
Interview Guide for On-Site County Interviews 220
Phone Survey: Client Satisfaction 238
Phone Survey: Why Do Clients Turn Down Services? 243
MA Patient Medical Plan of Care Evaluation and Referral Form . . . 247

B. Statutory Language 249

C. Summary Description and Evaluation Findings From Selected Programs Reviewed In Developing The Community Options Program 253

D. Level of Care Definitions 260

E. Community Services Definitions 269

LIST OF TABLES

Table		Page
1.	Counties Volunteering To Operate Community Options Programs in 1982 and 1983	10
2.	Characteristics of 1982 Volunteer COP Counties	11
3.	Nursing Home and Hospital Supply in COP Counties	13
4.	Nursing Home Admissions in 1981 by Primary Payer at Admission	14
5.	Allocation of Monies to 1982 Volunteer Counties	17
6.	Expected Units and Unit Rates For Categories of COP Funding	17
7.	Tentative 1983 Allocation For The Community Options Programs	20
8.	Dane County Phase-In Plan	32
9.	Dane County Designation of Persons To Do Assessments	35
10.	La Crosse County Phase-In Plan	45
11.	Pepin County Phase-In Plan	59
12.	Portage County Phase-In Plan	71
13.	Racine County Phase-In Plan	92
14.	Rusk County Phase-In Plan	104
15.	Waupaca County Phase-In Plan	117
16.	Waupaca County Allocation of Persons To Do Assessments	120
17.	Winnebago County Phase-In Plan	131

LIST OF TABLES

Table		Page
18.	Referrals By Age/Disability Group	150
19.	Categorically Disabled Referrals By County	151
20.	Referrals By County and Age/Disability Group	151
21.	Referrals Per Month By County	152
22.	Referrals By Location When Referred	153
23.	Number of Referrals By Location When Referred and County	153
24.	Referrals By County Action	154
25.	Referrals By County Action and County	155
26.	Persons Not Assessed By Age/Disability and County	155
27.	Percent of Persons Referred Who Were Not Assessed By County and Reason Not Assessed	156
28.	Clients Assessed By Age At Assessment and County	157
29.	Persons Assessed By Level of Care and Type of PPOC	158
30.	Percent of Cases Assessed By Level of Care Designation and County	159
31.	Persons Assessed By County-Reported Pay Status and County	160
32.	Pay Status of Clients Assessed Through May As of December of 1982 (MMIS Data)	161

LIST OF TABLES

Table		Page
33.	Clients For Whom Case Plans Were Developed By Level of Care Designation	163
34.	Number of Services In Case Plans By Client Level of Care	164
35.	Average Number of Services in Case Plans Per County	164
36.	Case Plan COP-Funded Services By Number of Clients and COP Funds Per Month	165
37.	Percent of Clients Receiving Community Services By Level of Care	167
38.	Percent of Clients Receiving Community Services By Age/Disability Group and County	168
39.	Reasons For Terminating COP Clients From the COP Caseload	169
40.	Months of Services Provided To COP-Funded Service Clients Terminated By September 30th	170
41.	Days of Service Provided to COP-Funded Service Clients By September 30th	171
42.	COP Dollars Spent By September 30th By County	172
43.	COP Funding By Cost Per Day of Service and County	173
44.	Relationship of COP To Other Funding Sources	174
45.	Average Number of Services Provided To Clients Who Received COP-Funded Services	174
46.	COP-Funded Services By Number of Clients and Percent of Funds Spent Per September 30th	175

LIST OF TABLES

Table		Page
47.	Clients Receiving COP-Funded Services By Type of Services Received From Natural Supports	176
48.	Person Making Decision To Enter Nursing Home By County	181
49.	Reasons For Entering a Nursing Home	184
50.	Whether Respondent Felt The Client Got The Types of Services S/He Wanted	188
51.	Whether Respondent Thought Services Generally Met Client's Needs	189
52.	Whether Respondent Would Recommend COP To A Friend With Similar Needs	189
53.	Whether Respondent Thought COP Services Helped The Client With Their Problems	189
54.	Whether Respondent Was Generally Satisfied With The Services Overall	190
55.	Whether Respondent Thought They Would Go Back To The Same Agency If They Needed Help Again	190
56.	Negative Responses By Type of Respondent	190
57.	Satisfaction With Supportive Home Care	192
58.	Satisfaction With Case Management Services	192
59.	Satisfaction With Home Health Services	193
60.	Satisfaction With Home Delivered Meals	193

LIST OF TABLES

Table		Page
61.	Satisfaction With Transportation Services	194
62.	Evaluation of COP Assessment In Cases Where The Client Refused COP Services	195
63.	Evaluation of COP Assessment In Cases Where The Client Received COP Services	195

I. INTRODUCTION

PROGRAM DESCRIPTION

The Community Options Program was authorized by the state's 1981-83 biennial budget to provide community-based alternatives to nursing homes including the three state centers for the developmentally disabled.[1] The program is designed both to divert persons from entering nursing homes and to deinstitutionalize current nursing home residents who can be effectively served in community settings. Persons to be served by the program are those who are "seeking or about to be admitted to" nursing homes or state centers for the developmentally disabled as well as current residents of such facilities who "want to be assessed and receive long-term community support services." State guidelines for the program specified that persons would be eligible for services if they:

- have a long-term or irreversible illness or disability; and
- are seeking, are about to be admitted, or are referred for admission to a nursing home (including long-term care in the state centers for the developmentally disabled), or are current residents of such facilities; and
- are included within the county plan for gradual program implementation; and
- require on-going assistance to attain or maintain stability and functioning; and
- require at least periodic medical, restorative, or rehabilitative care.

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[1] The category of developmentally disabled includes persons who are disabled due to mental retardation, epilepsy, autism, or cerebral palsy.

Objectives of the program are:[2]

- o to enable non-institutional community arrangements to serve as more effective alternatives to institutional care;
- o to allow chronically disabled individuals greater choice and opportunity to lead lives as independent and valued as possible;
- o to achieve greater coordination among providers of long-term support services; and
- o to limit the need for institutional forms of care in a manner which will reduce the growth in institutional expenditures.

By funding and coordinating community long-term support services, the Community Options Program (COP) is expected to counteract the current fiscal incentives to place persons in nursing homes. The amount of additional funding to be provided for community long-term support services is limited to average 42 percent of the cost of placing persons in nursing homes/DD centers. (This 42 percent is equal to the state's share of nursing home costs for Medicaid-eligible persons.) These additional funds along with funding from other sources such as Title 20 of the Social Security Act and Title III of the Older American's Act, are expected to provide sufficient services to prevent many nursing home/DD center placements. It is expected that the total costs associated with serving individuals who can be maintained in the community will be no more than the costs of nursing

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[2] Wisconsin Department of Health and Social Services, Discussion of The Community Options Program, March 1981.

home care and that establishing a mechanism to identify and serve such individuals in the community will ultimately slow the rate of increase in demand for nursing home beds. In the long run, it is expected that the Community Options Program will help moderate future increases in Wisconsin's nursing home Medicaid expenditures. (Wisconsin's 1980-81 Medicaid expenditures for nursing home care, $504 million, were 24 percent greater than in the previous year.)

The Community Options Program was a product of the Department's long-term support initiative -- a series of efforts to develop a coherent and progressive state policy for meeting the treatment/support needs of individuals with chronic problems in the least restrictive, most normalizing settings possible. Like a number of other recent long-term support policies, the COP is designed to reduce/prevent institutional placements in cases where less restrictive settings are appropriate. Other policies designed to reduce/prevent institutional placements include the moratorium on nursing home beds; the increased Suplemental Security Income (SSI) supplement for elderly persons in alternate living arrangements; bonding authority for community-based residential facilities (CBRFs); the elimination of Medicaid reimbursement for ICF 3-4 nursing home care for geriatric patients; the policy of billing community boards 10% of the Medicaid rate for the care of DD center patients deemed appropriate for community placement; and Administrative Order 1.67, a series of procedures developed to provide services to Medicaid residents of selected facilities who are designated appropriate for community services or alternate care as a result of the annual inspection of care assessments that are conducted of all Medicaid residents in such facilities in the state.[1]

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[1] The nursing home bed moratorium and DD center charge took effect January 1982. Administrative Order 1.67 was issued March 31, 1980. The change in coverage of ICF 3-4 applies to admission on or after October 1, 1981. The terms ICF-3 and ICF-4 refer to personal and residential care. See appendix D for a description of ICF 3-4 care levels.

Relationship Between COP and Administrative Order 1.67

The appropriateness of the care provided to Medicaid residents of nursing homes, including the state DD centers, is reviewed each year by staff of the Division of Health's Bureau of Quality Compliance. These reviews, called inspection of care (IOC) reviews, are required by federal Medicaid regulations. As a result of these reviews, residents may be designated appropriate for community services or alternate care if they fall into any of the following four categories:

1. The resident may be able to benefit from community services while continuing to need their current living arrangement.

2. The resident who is determined by the IOC Team to be appropriate for a level of care reimbursable by the Medical Assistance Program, but with appropriate community agency services may be able to move to an alternate placement.

3. The resident is determined by the IOC Team to need less than a level of care reimbursable under the Medical Assistance Program thus terminating Medicaid skilled or intermediate care facility reimbursement.

4. Because of abusive, aggressive behavior or signs of mental impairment, the resident may need services which are not provided by the facility, thus requiring an evaluation by the appropriate agency to determine the need for services and/or a more suitable living arrangement.

Residents identified as being in these categories from the IOC review are referred to the county A.O. 1.67 coordinator who is responsible for coordinating arrangements to provide community services.

In their Community Options Program plans for 1982, volunteer counties were required to describe the methods they would use to coordinate COP activities with annual inspection of care referrals under Administrative Order 1.67.

Program Components

Community Options Programs include three components: 1) assessment, 2) case planning, and 3) service delivery and case management.

In the assessment phase, persons seeking or about to enter nursing homes/DD centers or current residents of these facilities are interviewed and detailed information about their medical and social needs, functional abilities/disabilities is obtained. Relatives, friends, and guardians are also often involved in this step. The assessment is mandatory for Medicaid-eligible persons as well as those expected to become Medicaid-eligible in six months, but others may waive the assessment.[1] Persons who are assessed are told about the type of arrangement that could be made to serve them in a community setting. If the person being assessed decides that she/he would prefer to be served in the community, and if community services are deemed feasible and financially viable, a case plan identifying the type and amount of services to be provided in a community setting is prepared for the individual. If the person continues to prefer community services after reviewing the case plan, community services and case management services are initiated. Through case management, one individual is designated to evaluate and coordinate the delivery of services to the client and authorize changes in the type or amount of services being provided based on changes in the client's needs.

Administrative Structure

Local Level

Legislation for the Community Options Program allowed three types of agencies to administer a county's program:

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[1] Amendments to Chapter 50 contained in the Laws of 1981 made it a class B violation for a nursing home to admit a patient who had not undergone a COP assessment if he/she was required to do so. Some of the county phase-in plans in 1982, however, made it possible for persons who were Medicaid-eligible or expected to become Medicaid-eligible in six months to also waive the assessment during the period of gradual implementation.

1) a county department of social services or public welfare,

2) a combined community services board with the powers specified in ss.51.42 and 51.437, or

3) a community human services board created under s.46.23.

The county board of supervisors was responsible for designating one of these agencies to administer the program, for appointing members to serve on a long-term support planning committee which was to develop a Community Options Program plan for the county and monitor the implementation of the plan, and for approving the county's Community Options Program plan.

Lead Administrative Agencies

Within each county, the agency designated to administer the program was responsible for organizing assessment activities; arranging service contracts; and providing for ongoing case management, periodic case plan review and follow-up services for any person receiving COP-funded services. The lead agency was also responsible for billing clients as appropriate for all or part of the cost of their services and for maintaining and reporting program and fiscal data concerning the program.

State Level

At the state level, administration of the program was assigned to the Department of Health and Social Services (DHSS). The Division of Community Services' Office of Program Initiatives was assigned primary responsibility for administering the

program. Staff from this office also worked with selected staff from the Division of Health, other bureaus in the Division of Community Services, and staff from two committees. One of these committees, the COP Advisory Committee, was established to develop and review guidelines for program operation. This committee was primarily composed of persons external to the Department. The second committee, the Long-Term Support Steering Committee, was an internal committee of persons in various divisions of the Department who were involved in other long-term support programs. Principal responsibilities of the Department of Health and Social Services were to:

- Coordinate the program with hospital discharge planners, inspection of care reviews, and the protective services system.

- Develop guidelines for implementing Community Options Programs.

- Develop criteria for and approve or disapprove county agency COP plans.

- Evaluate the cost-effectiveness of the program and the ability of the program to provide alternatives to institutional care of persons.

Regional Level

The regional offices of the Division of Community Services were also involved in administering the program by reviewing county plans and providing technical assistance to counties.

Models for the Community Options Program

Development of the Community Options Program was in part based on the experience of other programs which have been designed to provide community-based alternatives to inpatient nursing home care.

Major programs that were considered in developing the Community Options Program included:

- The Nursing Homes Without Walls program in New York,
- Virginia's pre-authorization of nursing home admissions system,
- Monroe County's Project ACCESS (New York),
- The Community Care Organization projects operated in Barron, La Crosse and Milwaukee counties (Wisconsin),
- The TRIAGE Project in Connecticut,
- The nursing home preadmission screening program in the state of Washington, and
- The nursing home preadmission screening program in Georgia.[1]

The summary of most of these programs presented in appendix C illustrates the extent to which these programs, like nursing preadmission screening programs in general, differ in terms of their purposes, the types of persons they serve, the types of services offered, and the approaches used to deliver services.[2] Because of the differences among these programs, and also because of differences

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[1] Part of the assignment given to the DHSS Committee (1.9) which proposed draft legislation for the Community Options Program was to become familiar with these programs.

[2] For a detailed description of the features of nursing home preadmission screening programs in 28 states see: J. Knowlton, 1982.

in the approaches used to evaluate them, it is not suprising that a review of the evaluations of most of these programs by the Urban Institute concluded that it is difficult to draw conclusions about the effects they have had on nursing home utilization, cost, and client outcomes.[1] Appendix C presents a summary of most of the programs reviewed in developing the Community Options Program and summarizes the evaluation findings regarding each to date.

COUNTIES VOLUNTEERING TO OPERATE PROGRAMS

In August of 1981, counties were invited to submit letters of intent for voluntary participation in the Community Options Program in calendar year 1982. Letters of intent, which were due by September 24th, were subsequently received from seventeen counties. By October 8, 1981, eight counties had been selected to participate in 1982.[2] In January of 1982, one of these counties subsequently decided not to operate a program so another county that had submitted a letter of intent was selected in its place.[3]

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[1] Margaret Stassen, February 1981.

[2] Parties involved in selecting volunteer counties included representatives of the Community Options Program Advisory Committee, (which included representatives of health and social services providers and consumers); representatives of health systems agencies and area agencies on aging; and the Department of Health and Social Services Division of Community Services, (central and regional office staff).

[3] La Crosse was given the allocation originally computed for Marathon County. Marathon, which eventually decided not to operate a program in 1982, was unique because it was the only applicant county proposing to have the 51 board serve as the lead agency. It subsequently reapplied for 1983.

All but two of the counties submitting letters of intent for 1982, plus fourteen additional counties have submitted letters of intent for 1983. Because one of the additional counties subsequently decided not to start a program in 1983, there will be twenty-eight counties operating COP programs in 1983. Table 1 presents the counties operating COP programs in 1982 and those that are expected to do so in 1983.

TABLE 1

Counties Volunteering to Operate Community Options Programs in 1982 and 1983

County	Health Service Area	1982 Letter of Intent	1982 Participant	1983 Letter of Intent[c]	1983 Expected Participant
1. Ashland	7			X	X
2. Barron	5			X[b]	
3. Brown	4	X		X	X
4. Calumet	3			X	X
5. Chippewa	5			X	X
6. Dane	1	X	X-------	----------	------X
7. Eau Claire	5			X	X
8. Jackson	5			X	X
9. Jefferson	1	X		X	X
10. Kenosha	2	X		X	X
11. La Crosse	5	X	X[a]------	----------	------X
12. Manitowoc	4			X	X
13. Marathon	6	X[b]		X	X
14. Marinette	4			X	X
15. Menominee	4			X	X
16. Milwaukee	2	X		X	X
17. Outagamie	3			X	X
18. Pepin	5	X	X-------	----------	------X
19. Portage	6	X	X-------	----------	------X
20. Racine	2	X	X-------	----------	------X
21. Rock	1			X	X
22. Rusk	5	X	X-------	----------	------X
23. Sauk	1			X	X
24. Shawano	4	X			
25. Trempeleau	5	X			
26. Vernon	5			X	X
27. Walworth	2	X		X	X
28. Washington	2	X		X	X
29. Waupaca	3	X	X-------	----------	------X
30. Winnebago	3	X	X-------	----------	------X
31. Wood	6			X	X
	Total	17	8	21	28

[a]Selected to replace the county which withdrew.
[b]Subsequently withdrawn.
[c]Counties participating in 1982 did not have to submit letters of intent for 1983.

Profile of 1982 Volunteer Counties

The eight counties that volunteered to operate Community Options Programs in 1982 varied considerably in size as well as urban-rural mix, per capita income, and elderly population -- factors which have been used as indirect indicators of demand for nursing home care.

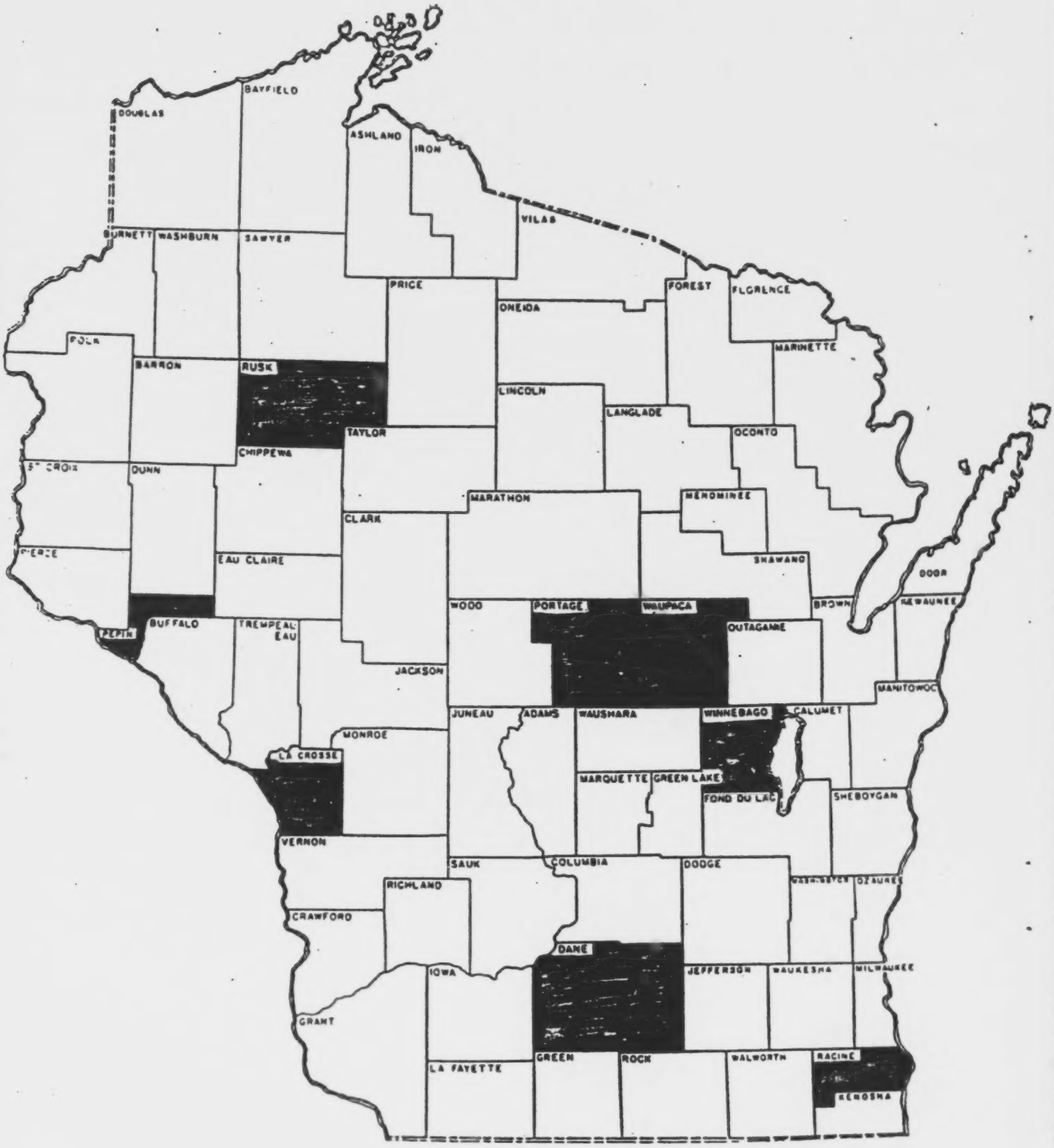
TABLE 2

Characteristics of 1982
Volunteer COP Counties

County	Total Population[a]	% Rural[a]	% 65 years and older[a]	Per Capita 1979 Adjusted Gross Income[b]
Dane	323,545	22.15%	8.36%	$7,243
La Crosse	91,056	26.02	12.08	5,883
Pepin	7,477	100.00	17.01	4,760
Portage	57,420	50.75	9.99	5,543
Racine	173,132	22.58	10.15	7,454
Rusk	15,589	75.46	15.16	4,269
Waupaca	42,831	67.36	17.39	5,474
Winnebago	131,703	20.52	11.61	6,641
Statewide	4,705,767	35.80	--	6,618

[a] Source: 1980 Census, Wisconsin Counties. STF 1. 1980. Tables.
[b] Source: Wisconsin Legislative Reference Bureau, State of Wisconsin 1981-82 Blue Book, page 667.

Figure 1 -- Location of Community Options Programs in 1982



The 1982 counties also varied considerably in the availability of nursing home as well as hospital beds. Five of the counties had fewer hospital beds per 1,000 population but higher nursing home occupancy rates than the state averages.

TABLE 3

Nursing Home and Hospital Supply
in COP Counties

	Nursing Homes[a]			General Hospitals[b]	
County	Number	% Occupancy	Licensed Beds Per 1,000 Pop. 65 yrs+	# of Hospitals	Beds Per 1,000 Pop.
Dane	29	91.7%	79.2	6	6.8
La Crosse	9	91.6	95.8	2	8.8
Pepin	2	96.8	119.0	1	4.1
Portage	2	97.6	63.9	1	3.6
Racine	8	95.2	57.5	3	3.3
Rusk	2	96.6	76.4	1	3.6
Waupaca	14	94.5	116.4	3	3.7
Winnebago	9	90.0	73.8	2	5.3
Statewide	454	92.4	--	145	4.8

[a] Source: Wisconsin Dept. of Health and Social Services, Division of Health, Bureau of Health Statistics Annual Survey of Nursing Homes 1979.

[b] Source: Wisconsin Dept. of Health and Social Services, Division of Health, Bureau of Health Statistics, Hospitals 1977, October 1979.

Collectively the volunteer counties accounted for twelve percent of the admissions to nursing homes in the state in 1981 who claimed Medicaid reimbursement at the time they were admitted.

TABLE 4

Nursing Home Admissions in 1981 By Primary Payer at Admission[a]

County	Medicaid	Other	Total	% of Medicaid Admissions	% of All Admissions
Dane	423	1,208	1,631	3.2%	5.8%
La Crosse	169	258	427	1.2	1.5
Pepin	51	59	110	0.4	0.4
Portage	123	48	171	0.9	0.6
Racine	306	375	681	2.3	2.4
Rusk	60	32	92	0.5	0.3
Waupaca	236	371	607	1.8	2.2
Winnebago	189	282	471	1.4	1.7
(8 County Subtotal)	(1,557)	(2,633)	(4,190)	(11.8)	(15.0)
Balance of State	11,643	12,048	23,691	88.2	85.0
Grand Total	13,200	14,681	27,881	100	100
Pct. of Total	47%	53	100		

[a] Reflects primary payer at time of admission. A number of persons who enter nursing homes also become eligible for Medicaid reimbursement after they are admitted.

FUNDING

A total of $943,400 was provided for the Community Options Program in 1982. These monies were provided in three separate categories:

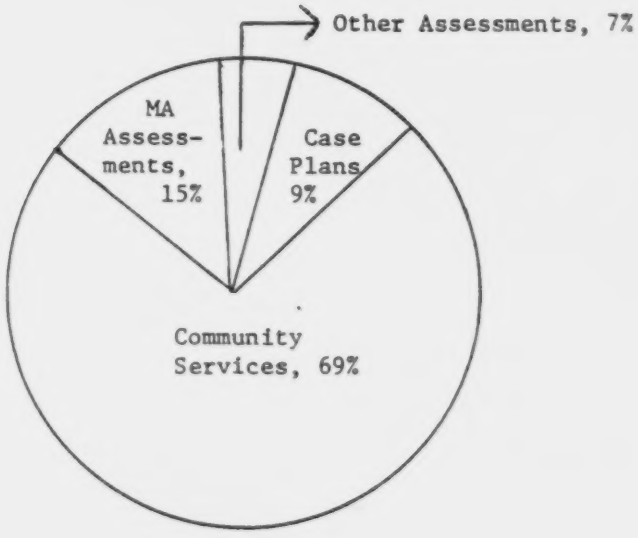
1) $649,200 to pay for community services for persons eligible for Medicaid or expected to become medically indigent within 6 months by spending their excess income for medical or remedial care.[1]

[1] The type of services that could be funded with COP dollars included all services covered by the Department's allowable cost policy. In general, all services which could be funded with MTA dollars could be funded with COP dollars. Services which could not be funded with COP dollars unless a special waiver was obtained included 1) services provided as part of care in an institution such as a nursing home, state DD center or child caring institution, and 2) services to persons residing in community-based residential care facilities larger than 15 beds in licensed capacity.

2) $152,200 to pay for the development of case plans for all persons assessed and for the assessment of persons who were not eligible for Medicaid. Although this category was subdivided into $82,199 for case plans and $69,999 for non-Medicaid assessments, counties could use the money for either purpose. They also could use any excess money in this category to pay for community services as described above.

3) $142,000 to pay for the assessment of Medicaid-eligible persons. (To be considered Medicaid-eligible, a person had to be certified eligible for Medicaid reimbursement for services provided during the time he/she was assessed.)[1]

Figure 2 -- State Funding For Community Options Programs in 1982



[1] The first two categories were included in the Community Aids appropriation. The third cateogry ($142,000), which included both federal funds and state matching Medical Assistance funds, was included in the state's Medicaid administrative allocation.

Funding Formula

The amount of money allocated to an individual county depended upon three factors:

1) the county's percentage of the state's average monthly medical assistance population during a six month period (February 1978 through July 1978),

2) the county's ranking on an urban-rural scale, and

3) the county's ranking determined by the ratio of the 1977 full value of taxable property in the county to the county's 1977 population.

The funding formula also stipulated that no county could receive more than fifty percent of the total funds available in 1982 and that for the first six months of 1983 no county could receive less money than they did in 1982.

Table 5 presents the monies allocated to the volunteer counties for 1982. Table 6, which follows, shows the maximum number of persons who could be assessed and for whom case plans could be developed as well as the number who could receive services according to the expected unit costs for these services. Guidelines established for the program stipulated that counties would receive no more than $60 for each assessment and $200 for each case plan. Reimbursement for community services was also expected to average $400 per month for each person receiving community services.

TABLE 5

Allocation of Monies to
1982 Volunteer Counties

County	MA Assessments	Other Assessments	Case Plans	Services	Total	Pct. of of Total
Dane[a]	$ 44,951	$22,159	$26,021	$205,511	$298,642	32%
La Crosse[a]	14,907	7,348	8,629	68,153	99,037	10
Pepin	1,947	960	1,127	8,900	12,934	1
Portage	10,758	5,303	6,227	49,183	71,471	8
Racine[a]	34,117	16,818	19,749	155,977	226,661	24
Rusk	3,688	1,818	2,135	16,860	24,501	3
Waupaca	8,196	4,040	4,745	37,472	54,453	6
Winnebago[a]	23,436	11,553	13,566	107,144	155,699	16
Total	142,000	69,999	82,199	649,200	943,398	100
Pct. of Total	15%	7	9	69	100	

[a] Each of these counties was offered participation at a "deferred implementation schedule" beginning April 1st. Although their allocations represented three-quarters of a year's funding, they were permitted to begin program operations as soon as their plans were approved.

TABLE 6

Expected Units and Unit Rates
For Categories of COP Funding

Category	Unit Rate	Allocation	Units Expected
Assmt - MA	$ 60	$142,000	2,367
Assmt - Other	60	69,999	1,167
Case Plan	200	82,199	411
Services[a]	2,600	649,200	250

[a] Service money is reserved to pay for services for persons who are Medicaid-eligible or expected to become Medicaid-eligible in six months. The total number of persons served therefore would be greater as it would include additional persons paying the full cost of their services. The number of persons served could also be greater because the pool of service dollars could be greater if counties transferred unused assessment/case plan money to pay for services. The $2,600 unit rate reported is based on assuming an average expenditure of $400/mo. per client and an equal number of clients starting to be served in each of the 12 months of project operation.

Client Fees

Legislation for the Community Options Program stipulated that persons who were not eligible for Medicaid and not expected to become eligible in six months were to be charged the full cost of services provided to them. The $649,200 provided for community services was allocated to pay for services provided to persons who were eligible for Medicaid or expected to become eligible in six months.

In October of 1981, the Department issued a report (Uniform Fees and Implementation of the Community Options Program) which outlined procedures which counties should use to determine if an individual client was eligible for cost sharing -- that is, eligible to have COP service dollars used to pay part or all of the cost of the community services provided to him/her.

The procedures specified one standard dollar amount ($7,500) to be used to determine if COP service dollars could be used to defray the costs of community services provided to an individual.[1] If a person's countable assets plus six months' worth of countable income was $7,500 or less, the plan allowed COP service dollars to be used to defray part or all of that person's community service costs.

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[1] $7,500 was calculated to be the statewide average cost of nursing home care for six months. For 1983, this will be $7,800 (adjusted for inflation).

The pilot cost sharing plan specifying these procedures also contained alternative methods which counties would use to determine the amount of cost sharing eligible clients' service costs that could be assessed as client fees.[1]

To cover the cost of services provided to clients eligible for cost sharing, counties could elect to 1) adopt either this pilot cost sharing plan or the Uniform Fee System (Wisconsin Administrative Code HSS 1) to assess client fees to pay for part of the cost of the services, or 2) to not assess client fees, using COP service dollars and/or other funding sources to pay for all of the cost of the community services provided.[2] Counties' pilot cost sharing plans had to be submitted to the Department of Health and Social Services for approval.

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[1] Under the plan, the very poor (the categorically needy) would be eligible for COP service funding with no required contribution to the cost of service.

[2] The pilot cost sharing plan is discussed in detail in the report Uniform Fees and Implementation of the Community Options Program.

Future Funding Level

For 1983, the tentative allocation for the eight original counties and the twenty additional counties starting programs in 1983 is as follows:

TABLE 7

Tentative 1983 Allocation For The Community Options Programs

Category	1983[a] (8 original)	(20 new)	Total
Medicaid assessments	$142,000	$ 760,200	$ 902,200
Other assessments	69,999	393,400	463,399
Case Plans	82,199	462,200	544,399
Services	1,592,598	1,763,200	3,355,798
Total	$1,886,796	$3,379,000	$5,265,796

[a] 1983 figures represent tentative allocations. .Actual amounts will be determined when the 1983-85 biennial budget is finalized.

The Department's budget request for the 1983-85 biennium included 29.3 million dollars to fully phase-in the Community Options Program -- that is, to initiate programs in all counties and to fund growing caseloads.[1] Counties operating programs may elect to do so gradually; they are not required to assess all potential nursing home residents or all current nursing home residents wishing to be assessed.

METHODS USED TO PREPARE THIS REPORT

This report is based on information reported to the Department of Health and Social Services by volunteer COP counties, on-site interviews of county staff and community representatives, telephone surveys of clients who were assessed by the

[1] 29.3 million includes both state and federal dollars.

program, patient records from the Division of Health's Bureau of Quality Compliance, and the Department's Medicaid Management Information System.

County Reports

Data reported by COP counties consisted of standard information on each of the persons who were referred, assessed, had case plans developed by, or received COP-funded services from COP counties. (COP reporting forms are presented in appendix A.) Referral and assessment reports were to be submitted one month after a client had been referred or assessed. Case plans were to be submitted a month after the case plan was prepared and service reports were to be submitted by October 31st for each of the persons who had received COP-funded services by September 30th.

In mid-November a listing of the reports submitted was prepared and returned to each of the COP counties to verify that they had reported on all of their program activities through September 30th. Reports were also edited by staff of the Division of Community Services as they were received, and counties were asked to supply any information needed to complete or correct a previously submitted report. In most cases, this additional or corrected information was submitted as requested. Edited reports were then coded and prepared for data processing.

On-Site Interviews

In September and October, staff of each of the eight COP counties and chairpersons of the COP planning committees were interviewed by staff of the Division of Policy and Budget. Staff interviewed included the COP program coordinator, the

Chair of the COP planning committee, and at least one other person who was directly involved in assessing COP clients, developing case plans, and/or providing case management services. In most cases, all of the persons from a county were interviewed at the same time. The interviews were based on a standard interview guide (presented in appendix A). After the interviews were completed, a narrative summary was prepared and returned to the persons interviewed. They were asked to review the summary and to note any material which needed to be revised to accurately reflect their program's operations or their opinions and attitudes regarding the program. Comments received were incorporated into the summaries which are presented in part I of this report.

Telephone Surveys

Two telephone surveys were conducted to obtain information for this report. The first survey was of clients who had been assessed by the COP program but who reportedly preferred to enter a nursing home rather than receive alternative services in the community. (County reports indicated that these clients or their guardians preferred nursing homes to community services.) The survey was designed to find out why clients preferred nursing home care.

The second survey was of a sample of the persons who had received COP-funded services by September 30th. It was designed to determine the level of client satisfaction with the community services provided.

Both surveys also surveyed client satisfaction with COP assessments.

Appendix A contains the questions used to conduct both of the surveys. A detailed discussion of the methods used to conduct the surveys and analyze the findings appears in chapter XIII.

Patient Records

An attempt was made to obtain standard information on the medical and social needs of each of the persons assessed by the Community Options Program. The vehicle selected to do this was the PPOC (MA Patient Medical Plan of Care Evaluation and Referral) form--the form which must be completed for all persons before they can receive Medicaid funding for nursing home care. Because the PPOC form was required for all Medicaid nursing home patients, copies of the PPOC forms which had been sent to the Bureau of Quality Compliance for persons assessed by the COP program who were applying for nursing home admission were obtained from the Bureau of Quality Compliance regional offices.[1] In cases where this form had not been completed for a person assessed (because he or she was a private pay client or because he or she was a Medicaid client but hadn't actually begun the process of nursing home admission at the time he or she was assessed), the county was asked to have the form completed either by the person's physician or, if this was not possible, by a nurse who was involved in the COP assessment.[2] Forms thus completed were then sent to Bureau of Quality Compliance regional office nurses and they were asked to review them and designate the client's level of care in the same way they did for all other clients.[3] The forms were then returned and information regarding the client's medical and social needs was coded and prepared for data processing along with

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[1] The Bureau of Quality Compliance is responsible for reviewing these forms to determine if the person is eligible for nursing home care based on his/her medical/social needs.

[2] Forms completed for the purposes of this evaluation were the same as those usually completed but physicians were instructed to omit the certification that inpatient nursing home care was needed, treatment goals and prognoses, and the level of care recommendation.

[3] The regional office selected to review the form depended upon the name of the nursing home the person was reportedly considering entering. If no nursing home was cited, the regional office was selected based on the COP county that assessed the person.

the other client-specific information obtained from the COP reporting forms.[1] Appendix A contains copies of the PPOC form and appendix D presents the criteria used to make level of care designations.

Medicaid Management Information System

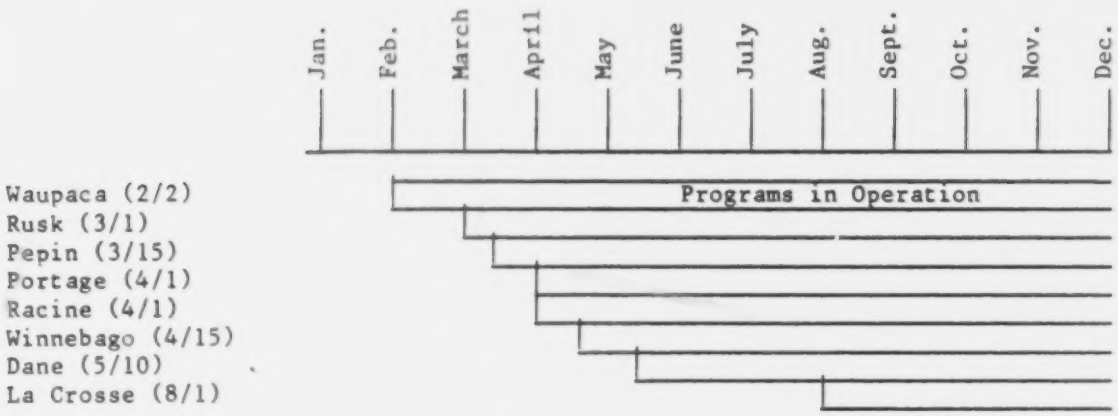
The last source of information for this report was the Department's Medicaid Management Information System. This system was used to obtain/verify client Medicaid status and to obtain information on the cost of health services.

[1] Because the format of the PPOC form had recently been revised slightly, the coding system covered both the older and newer report formats.

PART I: DESCRIPTION OF COUNTY PROGRAMS

This section of the report presents information obtained from COP county Community Options Program plans and from interviewing COP county staff and planning committee chairpersons.[1] Interviews were conducted in September and early October which, as figure 3 illustrates, was not very long after some of the programs began to operate.

Figure 3 -- Initiation of Community Options Programs In 1982



The interviews were conducted for several purposes. First, they were conducted to determine what local policies had been adopted to implement the program and if counties implemented their programs as they originally planned. In addition to

[1] A copy of the interview guide appears in appendix A. The methods used to conduct and verify the interviews are described in the preceeding chapter.

generating a detailed description of program operations, it was felt that this data would be of interest to the counties starting to operate programs in 1983. Secondly, the interviews were conducted to obtain information on the indirect effects of operating Community Options Programs. Thus counties were asked if they had developed new services with COP funds, if current services had expanded, and if the program had led to any changes in the policies and procedures of the lead or other agencies involved in operating the program.

Finally, the interviews served as a way to obtain county staff and community representatives' evaluations of their own programs. Thus persons interviewed were asked if they had been able to provide adequate services and arrange adequate living situations for the clients served; if they had been able to establish adequate communication with hospital staff, nursing home staff and clients' physicians; if they felt their assessment tool/process provided adequate information to plan services for clients; and what they felt were the most difficult and the most successful aspects of initiating their program. A summary of the findings from the county interviews appears in chapter X following the individual county reports. Readers not needing detailed information about the operation of individual county programs may wish to skip to chapter X (on page 141).

II. DANE COUNTY

CONTEXT

Planning Activities

Planning for Dane County's Community Options Program began in August of 1981 when a workgroup was established to review preliminary COP materials and draft a letter of intent.[1] On February 1, 1982, two consumer representatives and representatives of the following groups and agencies were appointed to the Dane County Community Long Term Support Planning Committee:

Skaalen Sunset Nursing Home
Dane County Human Services Board
Dane County Unified 51 Board
Health Planning Council
Dane County Department of Social Services
Regional Planning Commission
Visiting Nurse Service of Dane County
Dane County Commission on Aging
Madison General Hospital
Dane County Public Health Department

Members of this committee as well as representatives of a number of other hospitals, nursing homes, and agencies were consulted and public hearings held to

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[1] This workgroup later was designated a technical assistance group. It continued to serve as a support group to the planning committee throughout 1982.

develop Dane County's COP plan. The plan, which was finalized April 15, 1982, designated the Dane County Department of Social Services (DCSS) the lead agency. This was approved by action of the Dane County Board.

Lead Agency Role

As the lead agency, the Dane County Department of Social Services was responsible for: training persons conducting assessments and developing case plans, serving as a consultant to assessors, reviewing assessment reports, conducting selected assessments, deciding if case plans were to be developed for individual clients, contacting persons to participate in the case plan meeting, assisting potential providers in case planning, approving case plans and the assignment of case managers, monitoring the services provided to all clients, reimbursing service providers/assessors, and maintaining fiscal and program data.

Role of Other Agencies

Other agencies responsible for implementing Dane County's COP included four agencies (Dane County Commission on Aging, Access to Independence, Dane County Visiting Nurse Service, and Dane County Public Health Department) which were responsible for screening and assessing community referrals and nursing home admission referrals to COP, participating in case planning, and serving as case managers and service providers to selected clients. In addition, Stoughton Community Hospital and Madison General Hospital staff were responsible for screening/assessing hospital discharges.

Interagency Agreements

The Dane County COP plan specified that interagency agreements would be developed between the lead agency and other agencies serving COP clients or otherwise involved in implementing the Dane County COP. It was subsequently decided that purchase of service contracts would need to be developed between the lead agency and the other agencies which would be receiving funding from the lead agency (for assessment, case planning, or community services), and that letters of understanding would be developed between the lead agency and the agencies (such as referral sources) which would be involved in the program but not have any fiscal relationship with the lead agency. Dane County staff reported that it took only a minimal amount of time to develop letters of understanding, but that it took longer to finalize purchase of service contracts than they had expected and that the process was primarily delayed by a need to clarify the legal responsibilities of the affected agencies/individuals.

Planning Committee Role

The Dane County Community Long Term Support Planning Committee was responsible for approving the Dane County COP plan and monitoring the implementation of the program. It also recommended a number of policies to guide implementation during the first year. Except for a policy on the qualifications needed by persons doing COP assessments, the planning committee generally left administrative decisions to the discretion of the lead agency. Lead agency staff reported no confrontations between the planning committee and the lead agency during the initial months of program operation. Policy recommendations of the planning committee were generally viewed as "acceptable" to staff of the lead agency and

the planning committee was perceived as being supportive of the lead agency and a useful source of feedback from a lot of other agencies. The Chair of Dane County's planning committee also was the lead agency's COP project manager.

Eligibility Criteria

The Dane County plan specified that persons would be eligible for a COP assessment if they met each of the following criteria:

1. Dane County residency (using statutory language).

2. There is a physician's statement that: the client requires the services provided by a nursing home unless those services can be provided through community based care; and the client requires ongoing assistance to attain or maintain stability and functioning; and the client requires at least periodic medical, restorative or rehabilitative care; and the client has a long term irreversible illness or disability.

3. A statement signed by the intake agency that the client is a member of a target group included in the implementation plan.

4. A statement signed by the client or the client's family or guardian that nursing home admission is being sought, or that the client is covered under an A.O. 1.67 referral.

The fourth criterion was dropped after a few months of program operation because of the negative reaction clients - particularly elderly clients - had to signing

the statements. Some of the clients felt that signing the statement might authorize others to confiscate their property or the county would force them to enter a nursing home if they signed the statement.

Phase-In Plan

Dane County elected to implement its program by gradually taking referrals from thirteen referral sources during the year. Referral sources were selected to represent the mixture of referral sources that would be included when the program was fully implemented. The Dane County plan did not call for phasing-in persons according to any age, income or disability criteria. As table 8 indicates, referrals from some of the referral sources were received later than originally anticipated.

TABLE 8

Dane County Phase-In Plan

Referral Sources	Referrals Expected #	Referrals Expected %	Starting Month Plan	Starting Month Actual
Admissions to Nursing Homes	50	9%		
1. Skaalen Nursing Home			June 1	End of June
2. Dane Co. Hospital and Home			Sept 1	[a]
3. Black Earth Manor			Oct 1	[a]
4. Madison Convalescent Center			Oct 1	[a]
Admissions to State DD Centers	5	1		
5. Central WI Center			Nov 1	[a]
6. Southern WI Center			Nov 1	[a]
Hospital Discharges	250	45		
7. Stoughton Comm. Hospital			June 1	Sept 15
8. Madison General Hosptial			July 1	[a]
Nursing Home Residents	50	9		
9. State DD center or other nursing home residents referred to county A.O. 1.67 Coordinator			July 1	July 1
10-13. Community Referrals (Referrals to 4 access points[b])	200	36	May 1	Mid-May
Total	555	100		

[a] By the end of September, no referrals had been received from these sources.

[b] Includes: Dane County Commission on Aging, Access to Independence, Visiting Nurse Service, and Dane County Public Health Department. The role of these as well as the other access points in Dane County's plan is explained in the following section.

PROGRAM OPERATIONS

Intake Screening

The Dane County plan designated seven "access points" that were to be responsible for intake screening, assessment and case planning for persons referred to the program from the thirteen designated referral sources. These access agencies included:

1. Dane County Commission on Aging
2. Access To Independence
3. Visiting Nurse Association
4. Dane County Public Health Department
5. Madison General Hospital
6. Stoughton Community Hospital
7. Dane County Department of Social Services

The first four access agencies were responsible for screening admissions to the state DD centers and other nursing homes as well as referrals from the community received by each of the four agencies. The two hospitals screened hospital discharges referred for COP assessment. The Dane County Department of Social Services screened referrals identified by the county coordinator for A.O. 1.67 referrals and served as the back-up agency screening clients when no other staff was available to do so. Persons referred were reviewed by staff in these access agencies to see if they met all of the criteria for eligibility in Dane County's plan. Persons not meeting the definition were to be referred to other agencies that could provide services to meet their needs. Dane County staff reported that

from ten to twenty percent of the community referrals received by the first four access points through September had been found ineligible during intake screening. They expected the incidence of inappropriate referrals to decline when the program was fully implemented and better understood throughout the community.

The program found that the total number of persons referred in the first five months of program operation was less than they originally expected. They felt this was due to delays in finalizing interagency argeements with identified referral sources. By the end of September, the program had received approximately sixty-eight referrals, about twelve percent of the number expected for the entire year.

Although the staff reported getting fewer referrals than they expected from the referral sources identified in their plan, they also reported receiving a number of referrals from agencies and individuals not targeted in their plan. When referrals from sources other than those specified in their plan were received however, they usually were not assessed; rather, Dane County maintained its phase-in plan during the year. Exceptions to this policy included ten current nursing home residents who expressed a desire to return to the community who were assessed to gain experience and information on the cost and feasibility of serving current nursing home residents, and assessments for residents of Allen Hall (a community-based residential facility) authorized by the COP planning committee because the facility was closing.

Assessment

The Dane County plan called for the use of one standard assessment tool, but a decentralized assessment process whereby staff in each of the access point agencies would be doing the assessments. Authorized staff in the various

agencies received specialized training on the use of the assessment tool and were certified by the lead agency to conduct COP assessments. Table 9 describes the manner in which access point agency staff was assigned to do COP assessments.

TABLE 9

Dane County Designation of Persons To Do Assessments

Client Type	Assessment
1. Admissions to Central Center, Southern Center, and other nursing homes and community referrals to first 4 access points	Human Service Team composed of one medical and one social service staff person from two of the four access point agencies for community referrals.[a]
2. Hospital discharges	Hospital discharge planners in conjunction with medically trained personnel.[b]
3. Persons referred to Dane County A.O. 1.67 coordinator	Dane County Dept. of Social Services, COP social worker or social service aide and nurse from either the Visiting Nurse Association or Dane County Public Health.

[a] Includes: Dane County Commission on Aging, Access to Independence, Visiting Nurse Association, and Dane County Public Health Department.

[b] Includes: Madison General Hospital and Stoughton Community Hospital.

Staff reported that, to the extent referrals were received from each of the designated sources, the above allocation of assessment staff was followed in the initial months of program implementation. A problem encountered under this arrangement was that the $60 rate set to reimburse staff for doing assessments wasn't enough to reimburse them for their actual time.[1] For this reason, Dane County had experimented with having the nurse and social worker assess the client

[1] The $60 fee was divided equally between the nurses and social workers conducting COP assessments.

at different times, but they felt this wasn't as satisfactory as a joint assessment. Dane County staff reported that they were fairly sure the assessment tool they were using would be revised to make it shorter and more concise for the following year. They did feel that the tool provided good information for case planning and were confident that the tool was being used consistently by the various persons doing assessments.[1] Initial training had been provided to assessors and an informal group of persons doing assessments met monthly with Dane County staff to discuss assessment issues. As of the end of September, Dane County staff had not received any feedback on client attitudes toward COP assessments, but a comprehensive program evaluation, including a client satisfaction survey, was scheduled for completion by the end of 1982.

Case Planning/Management

Procedures

The process of case plan development was initiated when the Dane County Department of Social Services COP Unit social worker received a completed assessment report. This worker then contacted the client/client's guardian, the assessors and potential service providers to set up a case plan meeting. This meeting was used to select services, service providers and the case manager for a client. All of these decisions were described as mutual decisions. The Dane County Department of Social Services had final authority for case plan approval and a Dane County Department of Social Services social worker was always

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[1] The assessment tool was developed specifically for COP by the technical assistance group.

designated to "monitor" case plans. This monitoring included contacting clients at least once every six months, being available to resolve any issues that couldn't be taken care of by the case manager, and approving any changes to the case plan.

Dane County staff reported that usually only one of the two persons doing the assessments attended the case plan meeting and that if it appeared likely that one of the assessors would be designated the client's case manager, that person would want to attend the case plan meeting. Assessors who had been serving clients before they were given a COP assessment were described as likely to be designated that client's case manager. Dane County staff also reported that they were encountering some reluctance on the part of service providers to be case managers. In general they found staff more willing to do assessments and provide services than to serve as case managers.

Policies

Payment for Services. -- The case plan development meeting was also used to determine a client's income/asset status. If the client's income/assets were greater than allowed (by Medicaid regulations) Dane County planning committee policy was that the client could not be served by COP. (The individual was, however, eligible for the COP assessment and case plan.) In this situation, staff reported that if the assessors and case planners felt the person would need a case manager to maintain community services, the county department of social services would call a meeting with potential service providers to identify a case manager. The client, however, would be technically dropped from the Community Options Program at the point of service delivery whenever it was found that he/she exceeded Medicaid income/asset ceilings. Staff also reported that most

of the clients terminated from the program during the case plan process were terminated because they had too many assets. They also reported that they would have preferred determining client income status earlier, during assessment, but didn't feel that they could provide enough training to ensure that all of the different people doing assessments would be able to determine clients' income/assets consistently.

The income/asset policy was also cited as a reason for clients waiving assessments. Thus once clients were told they wouldn't get services if they didn't meet income/asset criteria, because the clients felt they knew what their needs were - and also what kind of services they needed - they didn't want to go through the assessment and case plan development processes.

The Dane County Community Options Program elected to charge for case management (drawing the funds from COP service dollars). It did not adopt a cost sharing plan for COP services because prior agency policy set no precedent for charging clients for other (e.g., Community Aid funded) services.[1] It was felt that adopting a cost sharing policy for COP would require many other agency-wide modifications.

COP dollars were characterized as being used to pay for residual fees for capped services. Thus if a service such as attendent care (for which Dane County had established a monthly ceiling) was needed by a COP client, if the cost of meeting a client's needs could be met by costs under the ceiling, no COP money would be used. If the client needed more services, COP would pick up the difference.

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[1] The term "cost sharing plan" is explained in chapter I.

Because of this policy, staff reported they hadn't used a lot of COP service dollars.

They felt that funding problems might occur in the future by following this policy because the COP would bring in new clients who would drain agency resources for existing services as well as generate waiting lists, thereby reducing their ability to provide services to persons not eligible for COP. They would prefer to have a commitment whereby they could use just COP service dollars for COP clients.

Ceiling on Cost of Diversion Services. -- The Dane County planning committee established a ceiling of $600 per month for COP-funded community services per client. This policy also allowed the case management costs for a client to exceed the ceiling for up to two months although all such situations were to be reviewed on an individual basis. During the initial months of project operation (May-September) no COP clients had been terminated from Dane County's Community Options Program because COP-funded services exceeded the recommended ceiling.

Feasibility of Providing Services. -- Staff reported that because most of the COP clients served in the initial months of project operation had been getting services before they were referred to COP, they hadn't had any clients for whom it would not be feasible to provide community services. They felt this was related to the way clients had been phased-in, that is, taking community referrals first. They expected this would be less true when hospitals were phased-in. They did note however that sometimes it wasn't known if services in the case plan were actually available in the community until two to three weeks after the case plan meeting.

Selection of Service Providers. -- In the initial months of program operation, most of the community services for COP clients were obtained from the four agencies serving as access points for community referrals as well as Independent Living, Skaalen Nursing Home and St. Mary's Hospital Medical Day Care Program, adult foster care, and individual attendent care providers. Staff reported that the client (or guardian) ultimately was responsible for selecting the agency/individual to provide services. Other factors considered in selecting providers included availability, cost, and prior experience with the provider.

INDIRECT EFFECTS

In the initial months of project operation, Dane County staff had not used COP dollars to expand existing services or to initiate new services. They felt that the lack of "up front" COP dollars and the need to link expenditures to specific clients would make it difficult to develop new services. They also did not feel that COP had had any effect on the policies/procedures of the other agencies participating in the program. The primary effects noted on the lead agency were an increased work load and a broader focus on interagency coordination. Staff noted the program had raised case management and referral issues that cut across agency lines and that the program was largely responsible for the preparation of a detailed inventory of existing services in the community.

AGENCY ASSESSMENT OF INITIAL IMPLEMENTATION

Dane County staff reported that the need to follow tight timelines was the most difficult part of initiating their Community Options Program. This was particularly difficult because of the large number of persons/agencies/groups

that needed to be involved in planning. They also felt that the fiscal reimbursement structure made it very difficult to operate the program. Because reimbursement was directly linked to the number of clients being served (a variable changing from month to month), they felt it was difficult to fund the fixed costs associated with operating the program. They felt that the lack of separate funding for administrative costs forced these costs to be taken from revenues intended for community services. This was seen as potentially damaging to the program and alarming to clients and community agencies which had been led to expect $400/month per client for actual community services.

They felt that their training program and the cooperation they had gotten from other agencies were strong points of their program during its initiation.

They felt that although communication with physicians regarding specific clients had been adequate, more efforts were needed to foster physician awareness of the Community Options Program. Communication with staff in hospitals was characterized as initially focusing on administrative issues and nursing homes were viewed as being generally ambivalent toward the program.

Overall they felt that they had been able to obtain adequate medical and social services for the persons served by their program and, because most of the clients served initially had kept their original living arrangements, they did not feel that client living arrangements hindered clients' activities or interfered with their health and safety. Dane County staff also felt that there were a lot of persons in the community who could benefit from the services provided through their Community Options Program. They expected to serve at least 50 persons by the end of 1982.

III. LA CROSSE COUNTY

CONTEXT

Planning Activities

La Crosse County was invited to submit a Community Options Program plan after Marathon County decided not to operate a program. A work group was appointed in May of 1982 to assist the planning committee in developing a COP plan.

The La Crosse County COP Planning Committee was comprised of one elderly and one physically handicapped consumer, and representatives of the following agencies:

County Board of Supervisors
Unified Services Board
County Aging Unit
County Nursing Department
Alliance for the Mentally Ill (also a consumer)
La Crosse Association for Retarded Citizens (also a consumer)

The plan, which was finalized July 29, designated the La Crosse Unified Services Board to be the lead agency.

Lead Agency Role

The lead agency was responsible for coordinating COP representative agencies, contracting services, billing and collections, financial and statistical

reporting, and case management and case plan review and follow-up for chronically mentally ill or developmentally disabled persons.

Inter-Agency Agreements

The La Crosse unified services board and the La Crosse County Department of Social Services established an inter-agency agreement that identified the functions and responsibilities of each agency.

Planning Committee Role

The planning committee's decisions are contained in the county COP plan. The committee generally followed the lead of a workgroup, consisting of agency staff.

There was some ambiguity regarding the present and future relationship between the lead agency and the planning committee. One respondent felt the committee was primarily advisory and another felt it was more directive. One respondent suggested that next year the committee might be incorporated into another standing committee of the La Crosse County Board.

Eligibility Criteria

La Crosse County used the state guidelines definition of COP eligibility, with the following limitations:[1]

[1] This definition appears on page 1.

a. The state definition of residency was used except for individuals in hospitals, nursing homes, state centers for the developmentally disabled, or a community based treatment facility. For such individuals, residency was defined as the individual's primary place of abode prior to admission to such facilities.

b. Individuals residing in nursing homes who were admitted to hospitals and then are readmitted to nursing homes were to be excluded during 1982 from COP eligibility.

c. Referrals from nursing homes or hospitals outside of La Crosse County were not accepted in 1982 with the exception of state DD centers which were included for 1982.

d. Eligibility for COP was to be determined by reviewing the threshold definition of COP eligibility and reviewing individuals covered under the plan of gradual implementation.

Phase-In Plan

The La Crosse County plan indicated the program intended to assess 60-80 people, with 40 percent of those assessments being developmentally disabled persons, 20 percent chronically mentally ill, and that 40 percent of all assessments would be

elderly or physically handicapped persons.[1] By referral source, the number of expected assessments in 1982 was:

Hospitals: 10
Nursing homes: 14
State centers: 5
Community: 10 elderly or physically disabled
7-15 developmentally disabled (DD)
Psychiatric Units of County Hospitals: 8

Table 10 presents the phase-in plan contained in La Crosse County's COP plan.

TABLE 10

La Crosse County Phase-In Plan

Month	Populations	Numbers To Be Assessed	Source of Referral
August	Persons W/DD	2	Community referrals
	Persons who are elderly	2	In own homes
	Persons W/DD	1	Central Center
	Persons W/DD	1	Northern Center
September	Persons W/DD	3	Community referrals
	Elderly persons or Phys, dis. persons	4	Nursing Homes and Community
	Persons W/CMI	2	Lakeview N.H.
	Persons W/DD	4	1.67 Lakeview N.H.
	Persons W/CMI	2	Psych Units

[1] As a condition of approving the La Crosse County plan, the Department of Health and Social Services required that they demonstrate an effort to serve the proportions of clients in different age/disability groups described above. This was done to ensure that in the first year, the program would serve clients in each of the disability/age groups. La Crosse was selected to replace a county which would have had a 51 board as its lead agency.

TABLE 10 (cont'd)

MONTH	POPULATIONS	NUMBERS TO BE ASSESSED	SOURCE OF REFERRAL
October	Persons with DD	2	Northern Center
	Persons with DD	1	Central Center
	Elderly or phys. disabled persons	8	Nursing Homes and Community
	Persons with DD	3	Community referrals
	Persons with CMI	2	Lakeview
	Elderly or phys. disabled persons	2	St. Francis Med. Ct.
	Elderly or phys. disabled persons	1	Lutheran Hospital
	Persons with DD	2	1.67 Lakeview referral
	Persons with CMI	2	Psych Units
November	Persons with DD	3	Community referrals
	Persons with DD	4	Non 1.67 Nursing Home
	Elderly or phys. disabled persons	5	Nursing Homes and Community
	Elderly or phys. disabled persons	2	St. Francis Med. Ct.
	Persons with CMI	2	Lakeview N.H.
	Elderly or phys. disabled persons	2	Lutheran Hospital
	Persons with CMI	2	Psych Units
December	Persons with DD	3	Community referrals
	Persons with DD	4	Non 1.67 Nursing Home
	Elderly or phys. disabled persons	2	Nursing Home and Community
	Persons with CMI	2	Lakeview N.H.
	Elderly or phys. disabled persons	2	Lutheran Hospital
	Elderly or phys. disabled persons	1	St. Francis Med. Ct.
	Persons with CMI	2	Psych Units
	Total	80	

PROGRAM OPERATIONS

Intake Screening

La Crosse County staff felt they got approximately as many referrals as they expected, but they got fewer referrals of elderly people in nursing homes than they expected. One reason offered for the lack of elderly nursing home referrals was that many people in La Crosse County nursing homes are not from La Crosse County and therefore not eligible for COP under the county's definitions.

La Crosse County COP staff reported that they were not able to process referrals as quickly as expected. This may have been due to circumstances unrelated to program design, such as employee illness and jury duty.

Assessments

The La Crosse County COP used the functional assessment tool developed by the Wisconsin Department of Health and Social Services (DHSS) to conduct assessments. The agency was dissatisfied with the instrument and planned to make major changes in 1983. Some stated problems with the form were that the form did not indicate why a client needs a particular service, was not applicable to children or disabled persons because it focused on the needs of the elderly, did not deal with the need for social integration or previous service involvement, and contained no description of natural supports.

It was suggested that rather than use an assessment instrument, it would be preferable to have an assessment report in narrative form, which would be developed by following an assessment process. Under the present system, one person said, the instrument becomes the assessment.

According to staff, the assessment tends to take much more time than expected, sometimes two to three days, because it is necessary to interview several people involved in the case and to complete the assessment form.

There were two agencies conducting assessments when staff were interviewed. It was felt that it was not necessary to ensure that consistent criteria were used. There were plans to have a peer review quality control system when additional agencies began to conduct assessments.

Finally, it was pointed out that La Crosse County will likely run out of service funds before they run out of assessment funds and that they do not intend to

conduct assessments for cases they cannot serve. It was thought that such a practice would cause disappointment among those assessed that would outweigh any benefits.

Case Planning/Management

Procedures

Assessment and case planning were part of the same process and were conducted by the same persons. Clients received case management as long as they got COP service funds.

Policies

Cost Sharing.--La Crosse County staff reported that they would apply some type of cost sharing mechanism in the future and that it had not become an issue because they had not yet served clients with an ability to pay.

Reimbursement Policies.--La Crosse County staff expected to begin charging the COP for case management in 1983. Staff reported that COP funds were used as a source of last resort and that it was relatively easy in La Crosse County to determine when other funds are unavailable because there were substantial waiting lists for most services.

Ceiling on Diversion Services.--There was no ceiling on the cost of services to COP clients in La Crosse County at the time staff were interviewed. It was noted that limits on services may be challenged in court, under the provisions of Chapter 55. (Staff stated that a court could require the county to provide services to a client in the least restrictive setting, regardless of cost, and even regardless of whether COP funds are available.)

Feasibility of Providing Services.--The final decision on feasibility was made by the COP coordinator. At the time staff were interviewed, no case plans had been turned down because they were determined to be not feasible.

It was suggested that feasibility is often based on how quickly services can be developed and delivered. One respondent also noted that there is an "economy of scale" issue in determining whether a service is feasible, so that a particular service (such as a specialized group living arrangement) may not be feasible for one client, but would become feasible if three or four persons needed the same service. This suggests that more specialized services will become feasible as the COP develops and larger numbers are identified with special unmet service needs.

Selection of Service Providers.--La Crosse County does not have several duplicate providers for most services. If a situation arose where equally acceptable providers offer the same service, the agency reported they would probably leave the decision up to the client.

Relating to the issue of provider selection is the fact that the La Crosse County Board recently required the agency to seek bids for supportive home care, and contract only with the least expensive provider. This rule may apply to other service providers in the future. With such a rule in effect, there would likely be only one provider of each service.

INDIRECT EFFECTS

Expansion of Existing or Development of New Services

At the time the interviews were conducted, the agency was in the process of using COP funding to develop a group living program for developmentally disabled youth with significant behavioral problems. In the future, they hoped to develop a service coordination program for adults with cerebral palsy and a pre-vocational program for developmentally disabled adults.

Because there were waiting lists for many social services in La Crosse County, and COP funds were used to provide those services to COP clients, a wide array of services were being expanded with COP funding.

Effects on Lead/Other Agencies' Operations

There reportedly has been little change in the operations of agencies as a result of the COP. This may be attributed to a prior philosophy in county agencies which is consistent with the philosophy of the COP. One respondent suggested that this philosophy, in turn, resulted in part from the Community Care Organization demonstration project, in which La Crosse County participated.[1]

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[1] The Community Care Organization demonstration project is described in appendix C.

AGENCY VIEW OF INITIAL IMPLEMENTATION

Most Difficult/Best Aspects

Respondents noted a number of difficulties in initiating the COP. State reporting requirements were seen as a problem. It was suggested that these requirements indicate a basic distrust of county agencies.

Staff felt counties should be trained in assessing human needs (specifically, in the principles of normalization). It was suggested that the state develop a PASS-type training program for counties that was shorter than the five day training usually required because many people may not attend PASS training because of the time commitment required.[1] Unlike existing PASS training, it was suggested that the workshop should also include situations in which an elderly person is in need of services.

It was pointed out that local agencies might tend to worry about getting committed to the COP because of fears that the program will end and they will be left with the greater demands and expectations generated by COP, but without the resources to meet them.

It was suggested that counties that are just beginning their planning process work to ensure that everyone who must participate in the COP be involved early in the planning. Staff felt that although this might create additional work in the planning phase, it would tend to ease implementation. It was also suggested that individuals or groups who might pose special problems should be identified early and targeted for special attention. A final observation regarding the planning

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[1]PASS training focuses on the principles of normalization.

process was that the short time frame available to La Crosse County for planning seemed to contribute to a quick agreement among persons involved in the process.

It was also suggested that new COP counties be cautious not to "oversell" the program because funds are very limited and there should not be extremely high expectations created.

One respondent said that Division of Community Service's regional office staff still does not have the program knowledge of the COP that will allow it to replace central office as the source of information to the counties. And, until the regional office has that COP knowledge, La Crosse County staff will probably continue to call the central office directly with questions.

Finally, it was suggested that the program be funded at a higher level. The La Crosse County "diversion rate" was higher than expected and assessments cost considerably more than the $60 allowed by the state, according to one respondent. With the number and cost of persons already being served by the COP in La Crosse County, it is anticipated that service funds are entirely committed for 1983. Therefore, the lead agency will probably not conduct additional assessments unless service funds become available.

On the positive side, La Crosse County appreciated all of the help in planning that they received from the state.

Communication Between Social/Medical Staff

Staff reported they have had good communication with hospital staff where hospital social service workers are the contact point with the physicians. The hospitals in La Crosse reportedly were very aware of the need for community services and have good, active discharge planners.

La Crosse COP staff reported some trouble communicating with nursing home staff. An exception was Lakeview Nursing Home, a county home that "serves people no one else wants." Lakeview staff were reported as being very receptive and cooperative with the COP. Most nursing homes did not send representatives to information sessions and there was reportedly some information distributed by a nursing home association that left the homes with a bad impression of the COP.

Staff reported they had good relations with physicians so far, although it was suggested that relationships might change as referrals begin to come from hospital discharges because COP may be appearing to "second guess" the physician's decision to place a person in a nursing home. It was suggested by one respondent that physicians still tend to prefer nursing home care for their clients.

When the agency needs medical information as part of the assessment, the assessors tend to get it from the physician's nurse or secretary.

Adequacy of Services

As noted above, because of lack of services, La Crosse County intended to develop "social integration" services for the developmentally disabled and elderly and

services for adults with cerebral palsy. Although staff cited waiting lists for most existing services, the quality of available services was reported to be very good.

Adequacy of Living Arrangements

Living arrangements were thought to be adequate in La Crosse County.

Potential for Program Growth

One respondent thought that the program has been most successful with low functioning persons with twenty-four hour per day needs and with persons with dual diagnoses (e.g. a developmentally disabled person with mental health problems). It was felt that there is considerable potential for expanding the program to serve persons in these categories.

IV. PEPIN COUNTY

CONTEXT

Planning Activities

The Pepin County COP Planning Committee was appointed by the Chair of the Pepin County Board on November 27, 1981. The planning committee was comprised of two consumers, and representatives of the following agencies:

Pepin County Board of Supervisors
County Health and Homecare Program
Department of Human Services
Commission on Aging
Chippewa Valley Hospital
Pepin Manor Nursing Home
County Housing Authority

The planning committee also obtained input from the community and from area hospitals. Pepin County's COP plan was submitted to the Department of Health and Social Services on February 5th.

Lead Agency Role

The Pepin County Department of Human Services was designated lead agency for the COP project. The lead agency was responsible for coordinating the COP planning committee, coordinating public information (including developing informational

flyers regarding COP and the referral and assessment process) and for compiling and distributing assessment materials to nursing homes, hospitals, physicians, community agencies and others in Pepin County.

The lead agency also had case management responsibilities when COP funds were used for a part of the community support plan.

Interagency Agreements

It was felt that there was no need for formal interagency agreements, perhaps because of the small number of agencies involved and their history of informal cooperative associations.

Planning Committee Role

The planning committee developed the plan and is thereby responsible for the policies contained in the plan. Staff reported few "policy" questions since the plan was finalized. The committee did ask to approve the persons selected to assess clients reportedly because some members wanted to ensure that these persons would be acceptable to the client group.

The planning committee's decisions were considered directives to the lead agency, although the lead agency reportedly advised the committee as to what was possible.

The committee met monthly and received written and oral reports on program progress from the coordinator. The committee expected to meet monthly through

the remainder of 1982. In addition to its role in planning the Pepin County COP project, the planning committee was also responsible for monitoring COP and coordinating and/or developing additional resources for COP.

The committee was described as moving beyond being solely concerned with the COP and toward a role as advocate for the client groups. For example, it was noted that there was a need for adequate low cost, accessible housing for the elderly and handicapped in Pepin County. The planning committee was approached by a developer to explore housing needs. There was an expressed hope that the committee could continue to meet even if the COP planning function was unnecessary. In general, committee members and lead agency staff were satisfied with the role and functioning of the planning committee in Pepin County.

Eligibility Criteria

The Pepin County plan specified that any individual who says s/he plans to enter a nursing home and requests an assessment would receive one. The county COP plan included additional criteria for selecting persons for assessments which would only be used if the number of referrals necessitated a waiting list. However, because no waiting list was developed, these additional criteria were not used.

Phase-in Plan

Voluntary referral clients were served in the first six weeks. All Medical Assistance-eligible clients were considered after that point. Table 11 presents the number of assessments expected.

TABLE 11

Pepin County Phase-In Plan

Referral Source	#	%
Hospitals[a]	20	40
Nursing Homes	15	30
Community	15	30
State Centers	0	-
Psych. Hospitals	0	-
Total	50	100%

[a] Includes out-of-county hospitals.

PROGRAM OPERATIONS

Intake Screening

The only intake screening that was done was that the assessment team asked the client if s/he plans to enter a nursing home.

If a person was referred but not assessed, because they were not in the target group or said they did not plan to enter a nursing home, staff reported they would be referred to an appropriate agency or elsewhere within the lead agency as the assessment team felt appropriate.

Pepin County COP staff reported they received more referrals than expected and enrolled the maximum number of COP clients funds would allow in a short time. The referrals came from a number of expected sources, including the hospital in Pepin, the community, and a nursing home. The lead agency expected a higher proportion of elderly referrals, but got a wider range of clients, including younger persons with physical handicaps, than expected.

It was noted that hospital referrals tended to come with very short notice before discharge, thus allowing little time for assessment, planning and the arrangement of services. There was an effort to work with hospital staff and physicians to get earlier referrals. (The local hospital had no discharge planner.)

The lead agency reported that referrals were processed as quickly as they expected, although some physicians would like the process to take less time.

It was reported that physicians were reluctant to refer patients to the COP. It was suggested that part of the problem of physician reluctance might have been solved if physicians had been involved earlier on in the planning of the program in Pepin County.

Assessment

Pepin County COP used the assessment tool developed by the Wisconsin Department of Health and Social Services, although they tended not to follow it rigidly. They were dissatisfied and planned to develop a new tool by 1983. The COP staff thought the tool they were using was unwieldy and, although it covered all areas, did not produce information in a usable form.

Assessments were done by a two-person team, made up of a social worker from the Pepin County Department of Human Services (DHS) and a nurse from the Pepin County nursing office. Staff thought clients were generally indifferent to the assessment process.

Case Plan Development

The nurse and social worker team that did the assessment also developed the case plan along with other service providers who might be involved, such as the area agency on aging, Kinship, etc.

Case Management responsibility was assigned to an existing staff member at the DHS or the county nursing office by the COP coordinator. If COP funds were used for a part of the community support plan, the case manager would be from the lead agency. The case manager contracted for services and authorized payment for services provided. Case managers also reviewed and updated case plans, at least once every six months.

At the time staff were interviewed, Pepin County had not yet discontinued case management for a case and had no policy for determining when that action would be appropriate. However, they reported case management would be discontinued if the coordinator thought it was no longer needed.

Cost Sharing

Pepin County required clients to use their own resources to pay for COP services until they were Medicaid-eligible. At that point, the client would pay nothing for the service.

Reimbursement Policies

In 1982, Pepin County absorbed case management costs for the COP program. Where possible, costs were charged to funds designated for the client's major disability group.

The planning committee was reconsidering this policy and it was reported that Pepin County may begin charging the COP for case management in 1983.

Ceiling for Diversion Services

Pepin County had set a limit of $200 per client per month on COP funding. There were no limits on services provided from other funding sources. At the time staff were interviewed, no one had yet been terminated from the COP for exceeding the $200 per month limit.

Feasibility of Providing Services

At the time staff were interviewed, there were no formal guidelines for determining the feasibility of case plans. After the assessment/planning team developed a case plan it was reviewed by the COP Coordinator, who evaluated the plan's feasibility.

The lead agency reported that two clients had been assessed but terminated from the COP because services were not feasible. In one case, the client's condition deteriorated. In the other, the client used COP services for a short period but requested to return to the nursing home.

Selection of Service Providers

Given the small size of Pepin County, there was no duplication in services available so that selecting among alternate providers was not an issue.

INDIRECT EFFECTS

Expansion of Existing or Development of New Services

At the time staff were interviewed, no new services had been started in Pepin County with COP funds, but attendant care was reported to be more available as a result of the COP.

There were no formal criteria or processes for determining which services would be expanded with COP funding.

Effect on Lead/Other Agency Operations

The COP reportedly had increased the staff workload, both within the human services department and the nursing service agency. It was noted that this increase resulted not so much from an increase in the number of clients, but from more intensive work with clients and the planning and process demands of the COP.

It was also suggested that the COP increased coordination among service agencies in Pepin County.

AGENCY VIEW OF INITIAL IMPLEMENTATION

Most Difficult/Best Aspects

A notable problem was the negative image the physicians and medical community had of the COP legislation. It was believed that this could have been avoided if the Wisconsin Hospital Association had been involved in the early state-wide planning of the COP.

Paperwork was cited as a problem, both in terms of volume and nature. For example, it is suggested that the agency should be informed well in advance that specific information will be required for reports because this would enable the agency to routinely record needed data rather than reconstruct the necessary data from records.

The agency noted some ambiguity in the instructions for preparing their 1983 plans.

It was also noted that more education of the public, physicians, and hospitals was needed to produce earlier referrals (i.e. referrals before a decision is made to enter a nursing home). Staff felt this could be accomplished, in part, by using existing networks such as the senior citizen newsletter produced by the area agency on aging.

According to agency staff, the timing of referrals was a problem. Once an individual had been convinced to enter a nursing home (or convinces himself/herself there is no other option available), the probability that two strangers (the assessment team) would change that decision was seen as being remote. In fact, the assessment was viewed as an intrusion to a person who is already in a weakened state of health. Realizing this, the planning committee has worked for earlier referrals. They felt that an earlier referral would avoid decision making in crisis and would allow for a more realistic assessment of needs and resources. To do this, the planning committee was relying upon the goodwill of the physicians, who are being asked to identify potential nursing home patients earlier, and upon formal and informal communication among client groups.

On the positive side, the agency was very happy with the way planning committee members became "salesmen" for the program. In addition, staff liked the flexibility of the program, the speedy responses by the state DHSS to questions, and the promises of less paperwork in 1983. Finally, there reportedly was a favorable community response to the COP: people reportedly thought the program saved tax money and provided a desirable form of care.

Adequacy of Services

Although agency staff said more funding was necessary to create attendant care services, they reported that social and medical service needs were probably being met at the level of "accepted community standards." Related to this, it was suggested that the general lack of knowledge of geriatric medicine among doctors throughout the country was reflected in Pepin County.

Adequacy of Living Arrangements

Staff noted that more funding was needed to create adequate housing. They noted a lack of low rent, accessible housing in Pepin County. Because of this, some living arrangements were reportedly less than satisfactory and some case plans were not feasible.

Communications Between Social/Medical Staff

Hospitals and physicians reportedly had not been referring persons for assessments in a timely manner in Pepin County. Most referrals of persons discharged from hospitals were received from the nursing homes after the person was discharged from the hospital. Nursing homes, on the other hand, reportedly cooperated very well with the COP.

The COP staff reportedly intended to work to improve communications with hospitals and physicians. It was suggested that there needs to be a general attitudinal change by many physicians to appreciate the role of social work and to enhance the atmosphere of mutual trust between medical and social service providers.

Potential for Program Growth

Pepin County had served mostly elderly clients in its COP, and it was noted that those most likely to be diverted were those who wanted to be independent. Although there is no measure of the number of persons who want to be independent, a relatively high proportion Pepin County's population is over 60 years old.

V. PORTAGE COUNTY

CONTEXT

Planning Activities

Planning for Portage County's Community Options Program included various community groups and agencies. One key group, the Interagency Coordinating Council of Elderly Services representing a variety of organizations, agencies and community groups serving the elderly in Portage County, recommended that Portage County apply for COP funding in July of 1981. The county board appointed the planning committee. Members included two consumers and representatives from the following agencies:

Portage County Commission on Aging
River Pines Community Health Care Center
St. Michael's Hospital
Portage County Community Human Services Department
County Board of Supervisors

The representative from the county commission on aging served as the chairperson of the Portage County COP Planning Committee.

The Portage County Human Services Department was designated the lead agency for the Community Options Program. Portage County's COP plan was submitted to the Department of Health and Social Services on February 23, 1982. An addendum to the plan providing supporting information was submitted March 31, 1982.

Lead Agency Role

As the lead agency, the Portage County Human Services Department was responsible for screening referrals, assessing clients in settings other than hospitals, developing case plans for all clients, serving as case managers, reimbursing service providers, disseminating information about the program, maintaining fiscal and program data for reporting purposes, and training assessors.

Role of Other Agencies

The only other agency directly involved in implementing Portage County's COP in 1982 was St. Michael's Hospital. Discharge planners at this hospital were responsible for identifying and assessing potential COP clients.

Interagency Agreements

Two interagency agreements were developed to implement Portage County's COP. The first, which was finalized in March of 1982, identified the responsibilities of St. Michael's staff with regard to the assessment process and the rate of reimbursement to be paid for assessments. The second, which was finalized September 1, 1982, was an agreement with Portage County Home regarding the provision of medical day care to COP clients.

Planning Committee Role

Portage County's planning committee was responsible for approving the COP plan, setting policy regarding program implementation, and monitoring program operations. Staff felt that policy decisions of the planning committee were

directives that should be followed. The committee was described as dealing with general policy issues such as cost sharing and criteria for client eligibility. In the initial months of program operation, the committee had not focused on administrative issues such as staffing.

The planning committee monitored program operations by reviewing statistical reports and receiving verbal reports at monthly meetings. The committee had also reviewed one case history in detail. It was noted that the planning committee was gradually adopting more evaluative techniques.

In general the planning committee was characterized as an active group that asked a lot of questions and served to represent other agencies and groups in the community. The planning committee felt it could have a stronger role and would as they become more informed regarding services.

Eligibility Criteria

The addendum to Portage County's COP plan indicated that individuals eligible for the COP in Portage County would be Portage County residents who:

- Have a long term or irreversible illness or disability; and

- Are seeking, are about to be admitted, or are referred for admission to the Portage County Home, River Pines Community Health Care Center, or Northern and Central Centers for the Developmentally Disabled; or are current residents of the facilities; and

- Are included within the Portage County plan for gradual program implementation; and

- Require on-going assistance to attain or maintain stability and functioning; and

- Require at least periodic medical, restorative, or rehabilitative care.

In determining eligibility, staff reported that they looked for clients with conditions that were likely to be permanent and that they considered a person to be seeking nursing home admission if the person or members of the person's family indicated they were looking at a nursing home or that the person was at risk of entering a nursing home. They noted that often it was the person's family that decided if the person would enter a nursing home. Staff did not report making any modifications in their eligibility definition during the initial months of project operation.

Phase-In Plan

Portage County's plan for gradual implementation specified serving only Medicaid-eligible clients during April-June. Within the category of Medicaid-eligible referrals, persons were to be phased-in to the program according to referral source and disability group. The plan indicated that in mid-July they would begin serving persons who were not eligible for Medicaid. These persons were also to be phased-in by referral source. The plan also noted that although community services would not be provided to non-Medicaid eligible elderly persons prior to July 15th, referrals would be accepted for assessments and case plans developed for such persons prior to July 15th. As table 12 indicates, some of the referral sources were phased-in slightly later than originally anticipated.

TABLE 12

Portage County Phase-In Plan
(Per March 31st Addendum)

Referral Source	Assessment Rate: Per Month	Assessment Rate: Total Cumulative	Assessment Rate: %	Starting Month: Planned	Starting Month: Actual
Hospital Discharges					
1. MA eligible discharges from St. Michael's hospital referred to the Portage County Home or the River Pines Community Health Care Center	9	81	52%	April 1	April 5
Nursing Home Residents	2	14	9%		
2. Portage County Home:					
a. MA Eligible Elderly				June 1	June 1
b. Elderly Not MA Eligible				July 15	Aug. 1
3. River Pines Community Health Care Center:					
a. MA Eligible Elderly				June 15	June 1
b. Elderly Not MA Eligible				July 15	Aug. 1
c. Developmentally Disabled				August	Aug. 1
4. Northern Wisconsin Center	[b]	4	2%	August 1	
5. Administrative Order 1.67				August 1	
Community Referrals	11	55	35%		
6. Elderly Not MA Eligible				July 15	Aug. 1
7. MA Eligible Elderly				[a]	April 15
8. Developmentally Disabled				August	August
9. Chronically Mentally Ill	1	3	2%	October 1	Sept. 1
Other Nursing Home Admissions					
10. Portage County Home and River Pines Community Health Care Center/Elderly Not MA Eligible				July 15	
11. State DD Centers				August 1	
Total[c]		157	100%		

[a] This referral source was not specified in Portage County's COP plan.

[b] Only the total number of assessments was specified for this cateogry.

[c] Portage County's plan did not specify the total number of referrals they expected to assess; it did indicate the number of assessments they expected to do each month by general referral categories. The reported totals are derived based on these figures and the original starting date for each of the referral sources.

PROGRAM OPERATIONS

Intake Screening

The lead agency's intake unit staff were responsible for determining if persons referred - including those referred from hospitals - were eligible for a COP assessment. Information on referrals received was then given to the COP coordinator who was responsible for assigning persons to conduct assessments. Staff indicated that information obtained to screen referrals included that required by the ICS (Title 20 Initial Contact Sheet) which was filled out for all referrals as well as information regarding the client's income, family support, and medical/physical condition. Clients found not to have chronic disabilities or not otherwise likely to enter a nursing home were considered ineligible for COP assessments and were referred to other units in the human services department or to the commission on aging as appropriate for services.

Staff reported that they got more referrals than they originally expected to in the initial months of program operation. Although they reported that referrals had come from the sources they expected to generate referrals, they were surprised at the extensiveness of the medical and emotional needs of the persons who had been referred. They noted that originally they had expected referrals to be clients needing (ICF 3-4) intermediate care, but they felt that all of those they were serving needed skilled care.

Staff were satisfied with the rate at which they had been able to process referrals. They reported that they generally were able to assign assessments within a day and that assessments were usually done within a few days of being assigned.

Assessment

Hospitalized Clients

Portage County's COP plan specified that hospitalized clients were to be assessed by hospital social services staff in coordination with and consultation from county personnel with COP responsibilities as well as the client, and client's family, guardian, or friends as appropriate. The COP coordinator was responsible for designating county human services department staff to serve as consultants to hospital staff conducting assessments. The assignment of county staff was to be done according to the client's disability using county human services staff already assigned to work with clients in each of four disability groups.[1] The assessment of hospitalized clients was to be done using the same assessment tool as was used for all other assessments.

Staff reported that in the initial months of project operation, hospitalized clients were assessed by the director of social services at the hospital and by the discharge planner who was a registered nurse and that staff assessing hospitalized clients had modified the county's COP assessment tool to make it easier to use and to obtain more medically-oriented data. County staff noted that assessing hospitalized patients was difficult because clients appeared differently in a hospital versus a home setting. They felt that the assessment of hospitalized clients was also difficult because the (hospital) staff conducting the assessments had different perspectives than did the county human services staff.

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[1] The Portage County Human Services Department had established staffing units for disability areas prior to applying for COP funding. Disability staffing units included elderly, mental health, developmental disabilities, and alcohol/drug abuse.

Other Clients

Portage County's plan specified that the assessment of clients not in hospitals was to be done by a team of two persons: the county human service department home health coordinator and a lead agency social worker from the agency staff unit serving other clients with the same disability. To implement this plan, one social worker from each of the four (disability) staffing units was selected to be responsible for COP assessments.

Clients who were new to the agency were assigned a social worker to do the assessment based on this structure; clients receiving services previously, however, would usually be assessed by the same social worker assigned to him/her previously. The assessment of non-hospitalized clients was also to be done in conjunction with input from family, friends, other agency staff, and a guardian (if appointed).

Portage County staff reported that due to the volume of referrals received they had to expand the number of medically trained persons responsible for conducting assessments. Instead of having all the assessments done by the county human services department home health coordinator, two nurses in the public health department as well as the nurses working in the home health program were trained to do COP assessments. Selection of a nurse to do an assessment also was based on who served the client previously. If a client had been receiving services from a public health department nurse before being referred to COP, that same nurse would be assigned to do the COP assessment.

Assessment Tool

Portage County Human Services Department staff reported that they expected to use the same assessment tool next year. They had revised the assessment tool twice during the initial months of project operation to obtain more personal background on clients. They felt that the persons doing the assessments were generally comfortable with the assessment tools they were using and that, except for the limitations associated with assessing hospitalized clients described earlier, the assessment process provided enough information to determine if a client was eligible for COP and the type of services he/she needed to live in a community setting.

Staff noted they had not received any negative feedback from clients concerning the assessment and that the only time they had found a client uncomfortable with it was when the client did not know why the assessment was being done.

Although they had not done any studies of the comparability of the assessments being done by different persons and in different settings, they felt that, for the most part, assessors had been using consistent criteria to assess clients.

They noted that some of the clients who had been assessed had been found ineligible for COP and that such cases were referred to the project coordinator who was responsible for final decisions concerning client eligibility. Clients found ineligible during the assessment were referred to other units in the human services department or to the Portage County Commission on Aging as appropriate for services.

Case Planning/Management

Procedures

The COP coordinator was responsible for assigning case managers to develop case plans and follow-up on the services being provided to clients served. The social worker involved in the assessment would usually be designated to be the case manager for a client, but if the COP coordinator felt that assigning a different social worker would be better for the client this would be done.[1] In this case, the case manager would be required to review the assessment results with the social worker who did the assessment and with the COP coordinator before he/she developed the case plan.

In the case of clients assessed when they were in a hospital, county human services department staff noted that it was sometimes difficult to link assessment and case planning. Procedures for doing so included the assigned case manager meeting with the hospital social service staff if he/she had questions concerning assessment reports and/or re-assessing the client after he/she had been released from the hospital, or meeting with the client/client's family to determine if the service needs identified during the assessment were still appropriate. In some cases, the person developing case plans waited to develop the plan until the person went home and his/her functioning in the home situation could be assessed.

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[1] For example, a client likely to be placed in a foster home having a number of persons assigned to a social worker other than the social worker who assessed him/her would probably be assigned to the second (foster home) social worker for case management services.

Once clients began receiving community services, the only reasons for terminating them from the COP program were if they elected to enter a nursing home or if they got better and thus needed less service. Staff reported that in the initial months of project operation none of the clients being served had been terminated for these reasons.

Case managers were responsible for personally contacting clients to follow-up on the adequacy of community services. This contact was usually made by a phone call. The amount of contact reported in the initial months of project implementation ranged from two to four calls per month.

Policies

Payment for Services. -- Portage County's original COP plan specified that they expected to use the uniform fee schedule from the Administrative Code (HSS 1) to bill clients for part of the cost of respite care, supportive home care, day care or any other services provided. When the addendum to their original (Feb 23rd) plan was submitted, however, it stated that they would use either the uniform fee schedule in the Administrative Code or the pilot cost sharing plan designed by the Wisconsin Department of Health and Social Services beginning July 15, 1982. When staff were interviewed in early October, they stated that they hoped to have a pilot cost sharing plan in place by October 15th. They indicated that they had decided to pursue a pilot cost sharing plan because it was consistent with the Portage County Human Services Department prior policy of charging clients for services and because it provided a broader view of where they could charge fees. This was seen as desirable because the human service department needed to capture

additional revenue to support its services. They expected that the pilot cost sharing proposal, once adopted, would also be used for the agency's Title 20 supportive home care program and would cover fees for case management services.

Delays in finalizing procedures for assessing client fees reportedly hindered the initial implementation of the COP in Portage County. Because the cost sharing plan had not yet been approved, when case plans were developed, clients were notified that they would have to pay a fee for services but the case manager was not able to tell them how much they would have to pay. In some cases because COP clients met the agency's financial criteria to receive supportive home care, if the client was uncomfortable with being a COP client because he/she did not know what he/she would have to pay for COP services, the case manager terminated the client from COP and started them on the Title 20 supportive home care caseload.

Agency policy for paying for the non-client share of the cost of services for COP clients was to use other available funding sources first if the client was on the agency's caseload before he/she was assessed through the COP. For all other clients, the non-client share was to be funded through COP funds. They did not anticipate charging private pay clients for case management services.

In general, agency staff felt that there were a lot of clients who needed COP services who did not have the ability to pay for the services.

Ceiling for Diversion Services. -- In the early months of project operation, Portage County did not establish any ceiling for the cost of COP-funded community services and therefore had not terminated any clients because services were too expensive. They reported that $400/month was a guideline and that actual costs

had reached as high as $900/month. Unusually expensive cases were discussed with the planning committee.

Feasibility of Providing Services. -- Case managers were responsible for deciding if it was feasible to provide services to individual clients. Services were judged feasible when the client preferred the services to nursing home care and the services were available or could be developed with COP or other funding sources. Inability to obtain or develop services was cited as the most frequent reason for judging services to be not feasible for specific clients. Staff reported that if a client had tremendous medical needs and no natural supports, the COP program was not able to serve the client. The program was also not able to serve persons who were confused and might be a danger to themselves. Other cases cited where the program was not able to obtain services included cases where they could not find twenty-four hour live-in attendant care and developmentally disabled clients who could not be served because day services were not available. Staff reported that in the initial months of program operation, some clients had been terminated from their COP because it was not feasible to provide/arrange community services. They noted that some of these clients were in nursing homes when they were assessed and that they were not referred anywhere else for services because the COP staff did not know of any alternative services available for them.

Selection of Service Providers. -- Case managers were responsible for selecting service providers. Staff reported that they did not have a number of agencies providing similar services in Portage County so they were not in the position of selecting among service providers.

The case manager was also responsible for authorizing changes to client treatment plans. Staff noted they had found it necessary to modify client case plans due to changes in the level of client needs or because providers (including natural support systems) failed to show up or got "burned out." These two factors were felt to be equally responsible for modifications to initial case plans.

INDIRECT EFFECTS

Service Availability

Staff reported that the availability of services had expanded in Portage County through the use of COP as well as other funding sources. Services cited as expanding due to COP money included initiating respite care for the elderly and adding twenty-four hour live-in attendant care services to the Title 20 supportive home care program.

Staff noted that COP money would also be used to support another service which had expanded -- day care services for elderly. This service has been initiated by the county nursing home with commission on aging monies.

Staff noted that because the COP reimbursement system did not provide any start-up money, it did not lend itself to the development of new services. They also noted that because only a small number of clients were being served by the COP program, as yet it had not had any impact on the caseloads of existing services and that the caseloads for supportive home care, and city and county housing, as well as the waiting lists for nursing homes in the county, had been declining.

Agency Operations

Except for the anticipated adoption of the pilot cost sharing plan, staff were not aware of any changes that had taken place in the policies/procedures of the human services department or other agencies due to the COP. They noted that the main effect in the lead agency had been an increased workload. They noted that the increased workload generated by initiating the COP program had been difficult to deal with because they had not hired any additional staff to operate the program and they also had been experiencing considerable turn-over in agency staffing. They felt the program had expanded their previous efforts to maintain clients in their own homes by formalizing and documenting policies and procedures they had previously been following. The program was also felt to have helped to improve communication between agency social work and nursing staff and that it helped the human services department staff communicate with the community at large.

AGENCY VIEW OF INITIAL IMPLEMENTATION

Staff reported that the most difficult aspects of initiating their program were establishing procedures to arrange for the assessment of hospitalized clients and trying to interpret guidelines for operating the program. They reported that their initial understanding of the type of clients to be served and how COP funds could be used turned out to be in error and that the initial confusion regarding these issues made it difficult to initiate the program.

Initially they felt COP was to be more of a preventive program serving persons before they actually began to actively pursue nursing home care. They later came to believe the program was to focus on diverting persons who were actively

seeking nursing home admission. They also reported that initially they had expected that COP monies could be used to develop services whereas they later found this was not possible.

Staff felt that other counties could avoid some of the start-up problems they had experienced if program guidelines were clarified and if one person was assigned to be responsible for all assessments - including those of hospitalized clients. They felt that assessments should be consistent and that this could be accomplished if a standard assessment was used and if the persons doing the assessments had an equivalent understanding of the community resources available for community services.

They felt that the initiation of the COP in their county was facilitated by pre-existing community support groups and human services department programs concerned with maintaining clients in their own homes.

Interorganizational Communication

Portage county staff reported that communication with hospital staff was just adequate and that there had been some improvement in communication since the program was started. Scheduling assessments soon enough prior to patient discharge was cited as a problem. In comparison, communication with nursing homes and physicians was described as good. Nursing homes were characterized as willing to help with assessments and refer clients being discharged and physicians as willing to discuss individual clients. A COP program representative had recently made a presentation about the program to the local medical association.

Other agencies described as having communication with the lead agency regarding the COP included the Portage County Commission on Aging which provided a family support program, meals, and respite care; the Commission on Industrial Corporation, which offered rehabilitation services; and St. Joseph's Convent, which provided living facilities for the elderly and had referred persons to the COP.

Adequacy of Diversion Services

Except for selected service gaps, staff felt they had been able to obtain adequate services for clients. Service gaps cited included day services for developmentally disabled clients, ensuring communication to cover possible medical emergencies for clients living alone, and social services for elderly clients with limited social skills. They noted that if a client was willing to take part in his/her service plan (i.e., by going to see his/her doctor as necessary), then adequate services could be arranged.

Staff also reported that in most cases clients maintained the living arrangements they had before they were assessed by COP. In about one-fourth of these cases, staff felt that clients' living arrangements were inadequate either because they did not provide adequate access given client physical impairments or because of structural or sanitary problems. They noted that if a client was willing to consider a different living arrangement, they would look at housing available through low income housing, foster care, or the U.S. Department of Housing and Urban Development.

Potential for Program Growth

Program staff reported that in the initial months of program operation they had found it easier to serve persons with less severe medical needs. They noted that serving persons with severe medical needs was difficult because 1) the services were very expensive, 2) in some cases the patient's condition continued to deteriorate so that in a few weeks, the client died or was required to enter a nursing home to obtain appropriate services. For these reasons they felt that their program was intervening too late and that it would be more cost-effective to serve clients with less severe needs (i.e., those needing intermediate ICF-1 or ICF-2 care).

They also noted that it was easier to serve clients who had natural supports that could help with their care as well as clients who did not live in isolated rural locations. Finally, clients in the county nursing home who had lived there for years were seen as difficult to serve because they had become so dependent upon an institutional setting.

Agency staff felt that there were a lot of persons in their county who could be served by COP, particularly if the persons on their supportive home care caseload were included. They noted however that some of the clients on their supportive home care caseload would not qualify for COP because they did not have chronic disabilities and were not at risk of institutionalization.

VI. RACINE COUNTY

CONTEXT

Planning Activities

Planning for Racine County's COP began in the fall of 1981 when the county human services department established an in-house planning and development committee for COP.[1] The Racine County COP Planning Committee was established January 26, 1982. It included two consumers and representatives of the following agencies:

Society's Assets, Inc.
Advisory Committee on Aging
St. Mary's Hospital
Racine Visiting Nurses Association
Lincoln Lutheran of Racine, WI
UW-Milwaukee, UW Parkside Campus
High Ridge Health Care Center
Developmental Disabilities Information Service
Mental Health Association of Racine
Racine County Human Services Department
Racine County Board of Supervisors
Racine County Human Services Board

Other groups consulted in developing Racine County's COP plan included the Racine County Hospitals and Nursing Homes Administrators Committee, the Conference of Agency Executives[2] and the Advisory Committee on Aging to the Racine County

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[1]This committee later served as the staff monitoring committee for implementation.

[2]Representing agencies providing health services and services for the elderly.

Human Services Board. A summary of the plan was also sent to fifty county agencies for comment. The plan, which was submitted in February, designated the Racine County Human Services Department the lead agency.

Lead Agency Role

As the lead agency, the Racine County Human Services Department was responsible for all aspects of COP implementation except intake screening and assessment of clients at two of the three hospitals included in their phase-in plan.

Role of other Agencies

The only other agencies directly involved in implementing Racine County's COP in 1982 were two hospitals which were responsible for intake screening/assessment of hospitalized clients and the agencies selected to provide services to individual COP clients.[1]

Interagency Agreements

Racine County's Human Services Department established interagency agreements for COP by contracting with the hospitals doing COP intake/assessment and by amending pre-existing contracts with service providers. A contract with one of the two hospitals was finalized in April and by the end of September, amendments to pre-existing contracts had been finalized with one of the service providers. (These amendments merely extended previous arrangements to include COP clients; they did not add any new provisions or requirements.)

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[1]Human service department staff were responsible for screening/assessing clients at one of the three hospitals included in Racine County's COP for 1982.

Planning Committee Role

Human service department staff reported that Racine County's COP planning committee was advisory to the human services board of the lead agency which was ultimately responsible for setting policy. They did not feel that policy recommendations of the planning committee were directives that had to be followed. Because of a delay in appointing members to the planning committee, members' involvement in developing Racine County's COP plan was limited. They did, however, review the plan and suggested some policy changes regarding services to children, and the person(s) who could request services. These changes were incorporated into the final plan. Planning committee members' activities to monitor Racine's COP included reviewing statistical reports, attending human services department staff meetings, and receiving verbal reports from human services department staff at monthly planning committee meetings. The planning committee felt that, in the future, they could serve as a forum for citizen questions/concerns about the COP. Reviewing community input regarding the program with human services department staff was one of the methods for program monitoring originally identified in Racine County's COP plan.

Eligibility Criteria

Racine County's original list of eligibility criteria for COP included the following elements:

1. Are seeking, are about to be admitted, or are referred for admission to a nursing home by a physician; or

   Are about to be admitted for long term care to a state center for the developmentally disabled; or

   Are current residents of nursing homes or state centers for the developmentally disabled; and

2. Have a long term or irreversible illness or disability; and

3. Are included within the county plan for gradual implementation; and

4. Require on-going sustenance to attain or maintain stability and functioning; and

5. Require at least periodic medical, restorative, or rehabilitative care; and

6. Are Racine County residents; and

7. Are residing in Racine County, hospitalized in Racine County, or residing in a state center for the developmentally disabled or a mental health institute and

8. Are 18 years or older.

Although the third part of the first element of the eligibility criteria indicated that all current nursing home and state DD center residents were eligible for a COP assessment, the Racine plan did not include current residents referred to the A.O. 1.67 county coordinator if they were in category 1 and 4 of the definitions.[1] Racine county staff reported that they did not feel such persons were appropriate for COP.

After a few months of project operation, Racine County's COP eligibility defintion was revised so that a physician referral to a nursing home was not needed. This expanded the group of eligible clients to include those with families/relatives who were seeking nursing home admission for them.

They made this change because they found that often it was the client's family who would seek nursing home admission and that the physician would not always be involved in seeking nursing home admission. Racine County staff reported spending considerable time in the initial months of project operation on a definition of "seeking."

The eligibility criteria was also revised to eliminate the age criterion. Staff reported that they originally thought it would be quite difficult to serve minors, but they later found that this was not the case; for that reason they modified their plan to include services to minors during the first year. (Originally, minors were not to be included until 1983 in Racine County.)

Other than the originally proposed exclusion of minors, the Racine COP plan did not propose prioritizing clients to be served by age, disability, or pay status.

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[1] These categories are explained in chapter I.

Phase-In Plan

Although Racine staff indicated they only expected to do half of the 849 assessments that could be funded by their COP allocation, primarily due to the low volume of referrals received in the first months of project operation, Racine County modified its original schedule for accepting referrals from various sources/agencies. Other reasons cited for modifying the original phase-in plan were that as the staff become more aware of how other agencies functioned, they found ways that the phase-in plan could be modified to make the program more efficient. Thus once they realized that a number of the designated referral sources had a central intake unit, they realized it would be more efficient to phase-in all of these sources at the same time. (This would allow them to train all of the staff as a unit and would make it easier for the referral sources themselves to identify potential COP clients.) They also found it better to phase-in the admissions from a number of nursing homes at the same time because this was easier for hospital discharge planners. They found that persons would be on the waiting lists for several homes. If some of these homes were included in the phase-in plan and others were not, it became difficult to decide if the person was to be covered by the phase-in plan. Racine staff also felt that once hospitals were included in the phase-in plan, in effect, admissions to all nursing homes in the community had also been included. Thus they felt the phase-in category of "new admissions to nursing homes" was redundant with the category of "hospital discharges." In general, revisions to Racine's phase-in plan placed more emphasis on nursing home admissions than on current residents of nursing homes. Human services department staff felt it would be best to take

care of assessing potential admissions first and then assess current residents. The revisions also included the state DD centers and patients in psychiatric hospitals from Racine County that originally were not to be phased-in until 1983.

Table 13 presents the original and the modified phase-in plans in Racine County and indicates when referrals were actually received from each of the targeted referral sources.

TABLE 13

Racine County Phase-In Plan

Referral Source	Expected Referrals No.	Expected Referrals Pct.	Expected Starting Date (1982) Original	Expected Starting Date (1982) Revised	Actual Starting Date
Hospitalized Clients	180	42%			
1. St. Mary's Medical Center			April	--	April
2. Memorial Hospital, Burlington			None	Nov.	Nov.
3. St. Luke's Hospital			None	July	July
4. Psychiatric Hospitals			None	June	June
Nursing Home Admissions	175	41%			
5. High Ridge Health Care Center			May	--	May
6. Westview Nursing Home			July	--	July
7. Lincoln Village Convalescent Ctr.			Aug.	Sept.	Sept.
8. Lincoln Convalescent Home			None	Sept.	Sept.
9. Becker-Schoop Nursing Home			None	Sept.	Sept.
10. Mt. Carmel Care Center			None	Dec.	Dec.
11. St. Catherine's Infirmary			None	Oct.	Oct.
12. State DD centers			None	June	June
Nursing Home Current Residents	20	5%			
13. Category 2 and 3 referrals to county A.O. 1.67 coordinator			June	--	[a]
14. High Ridge Health Care Center			Oct.	[b]	[b]
15. Westview Nursing Home			Nov.	[b]	[b]
16. Lincoln Village Convalescent Ctr.			Dec.	[b]	[b]
17. State DD centers			None	June	June
Community Referrals	50	12%			
18. Racine Co. Human Services Dept.			April	--	April
Total	425	100%			

[a] By the end of September, no referrals had been received from this source.
[b] These sources were dropped in June when the Racine plan was revised.

PROGRAM OPERATIONS

Intake Screening

Intake screening of all referrals except clients hospitalized at St. Mary's Medical Center and St. Luke's Hospital was done by the case management staff of the human services department. Hospital discharge workers were responsible for screening clients at St. Luke's Hospital and St. Mary's Medical Center. Because there was such a low number of referrals expected at the third hospital included in Racine's plan (Memorial Hospital, Burlington), human services department staff also screened clients there.

Racine County's COP plan stated that the criteria used for intake screening would include:

1. the definition for COP eligibility.

2. review of clients to be covered under the gradual plan of implementation.

3. determination of income eligibility status.

4. consultation with human service department case management staff.

However, staff reported that the second and third elements were not actually used to screen clients referred. Thus if a client was referred who met the definition for COP eligibility but was referred from a source not yet included in the implementation plan, the client would not be denied an assessment for that reason. In general they felt that it was a good idea to set up a phase-in plan

because it forced them to plan and let other agencies know when they would be included, but in practice it did not work to strictly follow the plan. They also indicated that although income eligibility status was determined during screening, it also was not a factor in deciding whether or not a client was eligible to be assessed. Rather it was determined to find out which clients had the right to waive the assessment. Private pay persons who did decide to waive the assessment were asked to fill out a waiver form. In general, human services department staff felt that they had been getting more private pay waivers than they should be getting and were considering various approaches to reduce the incidence of such waivers in the future.

Racine staff reported that they received fewer referrals than they expected, but that the number of referrals had started to increase each month. This increase was partly attributed to recent publicity given the program. They also felt that the type of referrals they had received (primarily elderly and physically disabled clients) was consistent with their original expectations.

Assessment

As with intake screening, human services department staff were responsible for assessing all clients except those at two of the three hospitals included in the phase-in plan. The human services department staff assigned to do COP assessments were social workers who also served as case managers for COP clients. Because no medically trained staff were directly involved in COP assessments, information on clients' medical needs was obtained by the social worker who called the clients' physicians. Physicians also reported clients' medical diagnoses, treatments, and medications by completing the physician part of the PPOC and returning this form to the human services department. Receipt of this form was required to open a case.

Hospitalized clients at St. Mary's Medical Center and St. Luke's Hospital were assessed by the discharge planners at those facilities. The human services department social worker assigned to do COP assessments was available to consult with hospital discharge staff.

Racine elected to use one assessment form for all COP assessments. The form adopted was a revised version of the assessment form the human services department had previously been using to determine the needs of clients requesting Title 20 supportive home care services. The revised version was also adopted for use by the Title 20 supportive home care case management unit and the agency intake/assessment process did not otherwise distinguish potential COP clients from potential Title 20 supportive home care clients. Any client who was assessed and found not to be COP eligible (according to the Racine County eligibility criteria) was referred to determine eligibility for Title 20 supportive home care services.

Racine staff were very satisfied with their COP/Title 20 assessment tool and expected to continue using it without modification. They felt that it provided enough information to determine clients' service needs and if they were eligible for COP. The COP coordinator had surveyed the staff doing assessments and found they, as well as clients, were comfortable with it. Racine County staff were also fairly confident that the tool was being used consistently by the various persons doing COP assessments although they had not done any studies of this issue. Previous experience with the tool was felt to be largely responsible for current satisfaction with its use. (This prior experience had given them a basis for refining the tool.) The only limitations cited in reference to the tool were

the sensitivity of some of the information obtained (i.e., substance abuse and financial data were mentioned as potentially embarrassing topics) and the need to supplement the information obtained with client observation, interviews and review of medical records. (This was mentioned for hospitalized clients assessed by hospital discharge planners.)

Although they were very satisfied with their assessment tool and completed it for all clients, Racine County staff felt that it was not necessary to complete all of the items on the tool if a client obviously needed more medical care than could be efficiently provided in a community setting.

Case Planning/Management

Procedures

Under Racine County's COP plan, case plan development was the responsibility of the case manager for the client. The supervisor of the case management unit to which the COP had been assigned was responsible for assigning case managers for COP clients.[1] If the client had previously been receiving services from the Racine County Human Services Department, he/she would keep the same case manager as he/she previously had. If the client was new, the case manager assigned would be the COP case manager who also did COP assessments.

The case manager developing case plans for COP clients was responsible for reviewing assessment results, notifying the client of the type and nature of

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[1]The Racine County Human Services Department has three case management units. COP was assigned to the unit which also was responsible for Title 20 supportive home care, therapist screening, child and family services, and stepparent adoption cases.

services available, determining client preferences, identifying service providers, notifying providers, requisitioning services, and reviewing plans at least every six months. Service providers were responsible for developing more indepth service plans for individual clients and notifying case managers of any changes needed in service plan.

In cases where COP clients had been assessed by hospital staff, the case manager developing a case plan for a COP client was also expected to call the hospital staff who had done the assessment.

The case manager's on-going involvement in monitoring case plans was described as varying by the type of client. In some instances, the case manager called or visited clients before the six month review to evaluate the services. In other cases, no client contact would occur unless the provider contacted the case manager.

Policies

Payment for Services -- Under Racine County's COP pilot cost sharing plan, persons with income or assets above that allowed, or otherwise not eligible, for Medicaid, could have part or all of their COP services paid for if it was judged likely they would become Medicaid-eligible within six months if they did enter a nursing home. Persons who were Medicaid-certified also could have part or all of their services paid for, whereas all other persons (i.e., "private pay clients" not likely in six months to become Medicaid-eligible) had to pay the full cost of service. These private pay clients would, however, be offered the option of

purchasing COP program case management services; they were not automatically dropped from the COP caseload. In the initial months of project operation Racine staff reported that few of the private pay clients who were offered case management elected to purchase this service.

In the case where client fees were not enough to cover the full cost of services, the Racine County Human Services Department policy for funding the remaining cost depended upon the client's prior status on the agency's caseload. If the client had been receiving services from the Racine County Human Services Department before he/she was assessed, the agency would determine the cost of the services provided previously. If the client needed more services than he/she was receiving previously, COP dollars would be used to pay for the non-client share of the additional services. If the client was a new client, COP dollars would be used to pay for all of the non-client share of service costs.

The only exception to the above procedure was case management. For this service, if a cost-sharing client was receiving other services for which he/she was paying part of the cost, then he/she was not charged for any of the costs associated with case management.

Ceiling on Cost of Diversion Services -- The Racine County Human Services Department did not establish any ceiling on the cost of providing services to a client. They did, however, terminate clients from the program when the client share of service fees exceeded the actual cost of the service.

Feasibility of Providing Services -- Racine County's COP policy regarding the feasibility of services was that the only situation in which services were not feasible was if a person needed twenty-four hours of actual care daily (i.e., not

just supervision, but direct services such as attendant care) and there was no source of natural support such as a relative, spouse or neighbor who could provide part of the care.

Selection of Service Providers -- In the initial months of project operation, most of the services for COP clients were obtained from private providers of medical services, supportive home care, and medical supplies; the visiting nurse association; private rehabilitation facilities; the human services department adult services unit; and a nursing home which provided meals-on-wheels and adult day care services. Selection of service providers was described as being based on client preferences, availability and the case manager's prior experience with specific providers. In general, if a client had been receiving services from a provider before s/he was assessed by COP, the case manager would try to continue the service arrangement. Supportive home care was the service most often provided.

INDIRECT EFFECTS

Service Availability

The Racine County plan identified 10 services which they expected to develop or expand with COP funds.[1] During the initial months of project operation, however, staff reported that because most services for COP clients were being obtained from large agencies and because few clients were being served, no

[1] Included were: adult day care, respite care, supportive home care, home modification, adult family home, guardianship, home delivered meals to persons less than 60, case management, placement assistance, and agency/system management.

services had as yet been expanded due to the program. They also felt that the lack of "up front" funding, the need to stay within the $400 per client per month average service expenditure, and the use of a twelve month accounting cycle would prevent them from developing any new services in the future with COP funds.

Agency Operations

Except for modifying billing procedures, the program was not felt to have had any effect on the operations of the other agencies doing assessments or providing services to COP clients. The main effect COP was felt to have on the lead agency was that it forced the development of client-specific program and fiscal data. (Agency staff were opposed to maintaining a client-specific information system.) Staff also noted that the COP program had made agency staff more aware of the resources available in the community as well as of the target group.

AGENCY VIEW OF INITIAL IMPLEMENTATION

Racine County staff reported that confusion as to who was eligible for COP assessments/services and their gradual plan of implementation caused the most difficulty in initially implementing their COP. They felt that their assessment procedures, training sessions, and the fact that people got services who otherwise wouldn't have because of budget cutbacks were strong points of their project start-up. They felt that for successful implementation it was important to think of training as an on-going activity.

Communication between human services department staff and nursing home staff was characterized as excellent. Nursing home staff were described as cooperating with the project by calling if they had a new admission who had not been assessed. Human services staff felt that, in general, most of the physicians in the county were not yet aware of the COP and that future efforts such as talking to the medical society were needed to foster physician awareness. Individual contacts with physicians were reportedly positive, however, with physicians being willing to supply data on clients as well as initiating referrals to the program.

Communication with hospital staff was described as o.k. Racine human services staff were reconsidering the decision to have hospital discharge planners do assessments. They noted that the COP cycle was difficult for discharge planners who were used to carrying out the entire discharge plan including identification of providers and that discharge planners tended to use different providers than did human services department staff.

Overall, they felt that they had been able to obtain adequate medical and social services for clients diverted. They also had not encountered any problems in securing adequate living arrangements for clients; most clients served had been elderly persons who maintained their original living arrangement. They expected that housing might be a barrier however when the program was expended to include a higher proportion of clients who were residents of nursing homes when they were assessed.

They felt that there were a lot of persons in their county who could benefit from their COP because they were aware of a lot of clients who needed supportive home care services.

VII. RUSK COUNTY

CONTEXT

Planning Activities

The Rusk County COP Planning Committee was appointed by the Rusk County Board of Supervisors on November 11, 1981. In addition to two consumers, the committee consisted of representatives from the following agencies:

Board of Supervisors
Rusk County Memorial Hospital
Rusk County Public Health Nurses
Rusk County Aging Unit
Rusk County Department of Social Services
Northern Pines Unified Services Center
Rusk Co. Personality Development Center

Representatives from the area agency on aging, the Wisconsin Department of Health and Social Service's Division of Community Services, and Ladysmith Nursing Home served in a technical advisory capacity to the committee. The COP plan for Rusk County was submitted in early February.

Lead Agency Role

The lead agency for the Rusk County COP was the Rusk County Department of Social Services (DSS). The DSS was responsible for program development, resource development, fiscal and statistical reporting, and for negotiating and approving all program-related contracts.

Interagency Agreements

The DSS had a formal interagency agreement with the Rusk County Public Health Nursing Service, the Rusk County Aging Unit, and Rusk County Memorial Hospital and Nursing Home. This agreement covered participation on the planning committee, reimbursement and information sharing.

It was felt there was no need for additional formal interagency agreements, perhaps because of the small number of agencies involved.

Planning Committee Role

In Rusk County there was overlap between active members of the planning committee and the agency personnel who administered the program. The same people tended to decide both policy and administrative issues.

Respondents felt the committee could have had more active consumer and physician representation. A physician was added to the committee after the plan was developed, but he has not been active.

Eligibility Criteria

Individuals who fell within one of the target groups covered by the implementation plan were eligible for assessment. Rusk County's plan included a fairly detailed and complicated set of criteria in its implementation schedule. Referrals were to be accepted according to the schedule shown in table 14.

TABLE 14

Rusk County Phase-In Plan

Client Group	#	%	Expected Starting Month
A.O. 1.67 Referrals			March
Community Referrals With MD Referrals to Nursing Home			
Less than 70 years old			March
Any age with multiple hospitalizations and receiving in-home services in last 3 months			March
(Subtotal)	36	39%	
Less than 75 years old and have family supports	3	3%	April
Less than 75 without family supports	9	10%	May
Persons with diagnosis of disease likely to be terminal in 6 months	9	10%	June
Individuals less than 80 years old	9	10%	July
Other Nursing Home Residents Who Request Alternative Services	27	29%	August
All other Persons Seeking Nursing Homes	NS[a]	--	September
Total	93	100%	

[a] NS = not specified.

The very restrictive phase-in plan was developed because the planning committee felt that there would be a great deal of demand for COP services and, given limited resources, they did not want the program overwhelmed with referrals.

PROGRAM OPERATIONS

Intake Screening

Rusk County staff reported they got fewer referrals than expected. At the time of the interview, Rusk County had had only four referrals and no COP cases. (The agency defined a COP case as one that receives COP service dollars.) The intent was to have the assessment interviewer screen referrals to determine if they were in the target group. But because of the low number of referrals, no intake screening was implemented.

The referrals were processed by the person designated to conduct the assessment interviews. The agency was able to process referrals as quickly as expected, within fourty-eight hours.

There were a number of reasons cited for the low number of referrals. First, there was a general physician reluctance to refer persons to the COP. The agency could not see a hospital patient without a written referral from the patient's physician. It was noted that there were problems getting information to the general public, including lack of media attention to the program. For this reason there were not as many community or client-initiated referrals as expected. Finally, because there are a number of community services available, and because the COP was a last resort choice, the demand for COP services was less than originally expected.

Assessment

A person designated by the COP coordinator conducted assessment interviews. The interviewer was not a service provider or member of the assessment team. The assessment team consisted of the COP coordinator, county nurse and perhaps a member of another discipline related to the client's needs. Rusk County used the Long Term Support Project Functional Assessment Tool developed by the DHSS, with some revisions. Changes included adding "interview impressions" and a "review summary" section. It was felt that the summary section was necessary because the assessment tool was too long to allow an overview of the client's needs.

Members of the assessment team thought the tool generally provided enough information to determine if a client was eligible for the COP and to determine what services would be needed. There will probably be more changes in the assessment instrument before 1983. The agency is considering adding a section on alcoholism.

Assessors reported some discomfort with questions relating to financial and memory problems. Clients reportedly tended to think there were too many questions, but they were willing to go through the assessment process if it could keep them out of a nursing home.

The agency reported needing more time for hospital patients before discharge (perhaps two days) to conduct an assessment, complete a case plan and arrange for services. COP staff also noted that it would be desirable to have time to present and explain the COP to clients and family members well before the patient was discharged to a nursing home.

Case Planning/Management

Procedures

Case planning was reportedly done at the same time as the assessment, and by the persons conducting the assessment.

Although there had been no cases to manage at the time of the interviews, decisions regarding case management were to be made by the COP coordinator. The intent was to appoint a case manager from the agency that provided the greatest amount of service in each case. The case manager would act as a contact person for the client and as a liaison between the client and providers. The manager would review the case plan monthly and was responsible for ensuring that clients were satisfied with services.

Policies

Cost Sharing.--Rusk County intended to use the pilot cost sharing system to ensure that clients with the ability to pay share in the cost of the services.

Reimbursement Policies.-- Rusk County intended to charge the COP for case management.

One of the stated reasons for not serving clients in the COP was that the agency used all available alternatives before using COP funds. As an example, when the agency developed its "care call" program (see below), rather than use COP funds, they used a grant from the area agency on aging to buy the equipment and Title 20 funds to implement the program.

Ceiling for Diversion Services.--There were no limits placed on service costs at the time staff were interviewed, but the COP coordinator was to review case plans for reasonability and feasibility.

Feasibility of Providing Services.--The COP coordinator was responsible for reviewing case plans for feasibility.

Selection of Service Providers.--At the time staff were interviewed, there was no policy in Rusk County on selection of service providers.

INDIRECT EFFECTS

Expansion of Existing or Development of New Services

Staff reported that there were new services developed in Rusk County in 1982, but not with COP funds. The agency, together with the Rusk County Aging Unit,

developed a "care call" system, whereby frail elderly persons receive a pocket-size device that calls for help in case of an emergency. They also developed a Senior Kinship Program and prepared a resource manual for elderly persons in the community.

Effect on Lead/Other Agencys' Operations

Effects of operating the COP cited by staff included the creation of extra work in Rusk County without providing additional staff and an increase in lead agency staff awareness of the needs of persons in the COP target group.

AGENCY VIEW OF INITIAL IMPLEMENTATION

Most Difficult/Best Aspects

Staff reported that the most difficult part of the implementation was physician resistance to the COP and physician pressure on patients to enter a nursing home.

They also reported problems in providing adequate public education and staff training. There was an expressed desire for training from the state on use of program guidelines, filling out forms, and for a "COP Hotline," with someone available to answer policy and procedural questions. It was also suggested that the state could conduct some public education on the COP. Finally, it was noted that there might be some advantage to using a consistent assessment tool from county to county.

The best aspect of the COP in Rusk County, according to the staff, was that the increased coordination that resulted from the project may have increased the effectiveness of existing resources and reduced the need for new resouces.

Communications Between Social/Medical Staff

Relationships with nursing homes and hospitals were reported to have been good whereas relationships with physicians were reported as not good. Staff noted that statewide planning meetings tended to identify physicians as the "enemy" so that when Rusk County developed its plan it chose not to involve physicians. Later it was decided that it was necessary to include a physician on the planning committee, but the person selected has not been attending meetings. It was noted that one physician in particular, was a key person in the community because he was the physician for many potential COP clients.

Adequacy of Services/Living Arrangements

Because no one had received COP services in Rusk County at the time of the interview, staff could not determine if services/living arrangements were adequate. Staff did however describe an instance of an elderly Medicaid-eligible couple that lived in a secluded rural area of Rusk County who were checked into a nursing home for the winter because their home was not adequate for winter living suggesting that living arrangements may be a problem in the future.

Potential for Program Growth

Given the fact that Rusk County had not yet served a COP client at the time of the interview, it is difficult to assess the potential for program growth in that county.

VIII. WAUPACA COUNTY

CONTEXT

Planning Activities

Planning for Waupaca County's Community Options Program started in August of 1981 when the Waupaca County Board authorized the county department of social services to submit a letter of intent.

Planning committee members were appointed in November of 1981. Included were two representatives of long term care services as well as representatives from the following agencies:

County Department of Social Services
County Health Services
Commission on Aging
Social Services Board
Unified Health Services
Clintonville Community Hospital
Manawa County Nursing Center

In addition to the planning committee, a number of other public/private agencies and groups were consulted regarding the county plan.

The Waupaca County Department of Social Services was appointed the lead agency for the COP. The Waupaca County plan was submitted in January.

Lead Agency Role

As the lead agency, the Waupaca County Department of Social Services was responsible for conducting or arranging assessments, developing and monitoring case plans, training persons to do assessments, maintaining program and fiscal data, reimbursing service providers, disseminating information about the program, and providing staff time to the planning committee.

Role of Other Agencies

Other agencies involved in implementing Waupaca County's COP included four hospitals, whose discharge planning staff were to refer and assess clients; the Waupaca County Health Service, which provided nurses to do COP assessments and participate in case planning; the unified health services agency, which was involved in assessment and case planning for selected clients; and a variety of agencies which provided community services.

Interagency Agreements

The Waupaca County Social Services Department had established a formal procedure for case management/service coordination with the unified health services agency before the COP was planned and written contracts were developed during the case plan meetings to identify the case manager and service providers for a client. No other contracts or inter-agency agreements were specifically established or planned to implement the COP.

Planning Committee Role

Waupaca County's COP planning committee was described as advisory to the Waupaca County Department of Social Services which was primarily responsible for implementing the program. The planning committee reviewed and approved the COP plan, was consulted regarding difficult decisions that had to be made concerning individual cases, and monitored program implementation by receiving periodic statistical reports. Both the lead agency and planning committee members were satisfied with the role of the planning committee. The planning committee was felt to be supportive of the lead agency, decisions were characterized as mutual, and no confrontations between the planning committee and the lead agency had occurred in the initial months of project operation. The only limitation cited regarding the role of the planning committee was that because most of the members had full-time jobs, their participation in program activities was limited. The Chair of Waupaca County's COP planning committee was an administrator of a nursing home in the county.

Eligibility Criteria

Waupaca County's COP plan indicated that persons would be eligible for a COP assessment if they were county residents who:

1. Have a long-term or irreversible illness or disability; and

2. Are seeking, or about to be admitted, or are referred for admission to a nursing home (including long-term care in the state centers for the developmentally disabled), or are current residents of such facilities; and

3. Are included within the county plan for gradual program implementation; and

4. Require ongoing assistance to attain or maintain stability in functioning; and

5. Require at least periodic medical, restorative, or rehabilitative care.

The plan also stated that to qualify as a COP client the assessment must indicate that there are essential needs of the individual that could be met in a nursing home. Only county residents were eligible for COP services during the first year and any county residents referred from out-of-county hospitals with a diagnosis of chronic mental illness had to have been hospitalized for at least seven days. The plan also stipulated that residents of state DD centers or county nursing homes who were referred to the county A.O. 1.67 coordinator would be screened to determine if they met the COP eligibility criteria -- such referrals were not automatically eligible.

Procedures for determining a client's eligibility included reviewing the client's medical diagnoses and the physician's prognosis for the client. County staff reported that to be eligible a client was expected to have some medical needs and require more than just custodial or limited term "one shot" care. The COP coordinator and the county nurse both reviewed cases to determine if they were eligible based on these criteria. To determine if a client was seeking or about to be admitted to a nursing home, staff reported they relied upon finding out if the client, client's family, physician or social worker felt nursing home admission was likely based on a deterioration in the client's medical/physical condition or an inability of natural support systems to continue to care for the

client. Staff reported that they often asked why the person was in more danger of going into a nursing home today than he/she was yesterday. They also reported that the plan of gradual implementation was not actually used to determine if individual clients were eligible to be assessed. A client referred who met all of the other eligibility criteria would be assessed even if s/he was not referred from a referral source currently included in the plan of gradual implementation.

Phase-In Plan

Waupaca County elected to implement its COP by gradually accepting referrals from each of the four hospitals in the county, out-of-county psychiatric hospitals serving county residents, state DD centers, community settings and nursing homes in Waupaca County. Referrals were to be accepted on a first come, first serve basis following the plan of gradual implementation. The phase-in plan did not specify any priority among referrals from different age or disability groups.

Because they did not receive as many referrals as they expected to in the first months of project operation, Waupaca County revised its original calendar for accepting referrals from each of the referral sources specified in their plan. By October, they had received referrals from each of the sources specified except out-of-county psychiatric hospitals and the state DD centers. Table 15 presents the original and revised phase-in plans for Waupaca County.

TABLE 15

Waupaca County Phase-In Plan

Referral Sources	Assessments Expected		Expected Starting Month	
	No.	Pct.	Plan	Revised
Hospital Discharges	152	79.0%		
Riverside Community Hospital			Jan	Feb
Iola Hospital			April	March
Clintonville Community Hospital			June	April
New London Hospital			July	March
Out-of-County psychiatric hospital	2	1.0%	Oct.	Oct.
All out-of-county hospitals, not psych.		-	-	May
Admissions to Nursing Homes[a]	-	-	-	May
Community Settings	30	16.0%	Oct.	March
Admissions To or Releases From State DD Centers	2[b]	1.0%	May	May
Nursing Home Residents				
Referrals from A.O 1.67	3[b]	1.5%	May	May
Other nursing home residents:	3[b]	1.5%	Dec.	May
Total	192	100%		

[a] This referral source was not specified separately in Waupaca County's COP plan. Persons in this category are included in the category of community settings.

[b] Subtotals estimated based on the grand total and the range of assessments expected to be done for each category. The Waupaca plan indicated they expected to assess 3 nursing home residents, 1-2 clients from state DD centers, and 3-5 residents referred under A.O. 1.67.

PROGRAM OPERATIONS

Intake Screening

The COP coordinator was responsible for screening referrals received directly or from the county social service intake unit. During a phone interview, the coordinator determined if persons referred were not eligible because they were not county residents or because they did not meet the first, second, fourth or

fifth parts of the eligibility definition. Clients determined ineligible from this screening were referred to other agencies/departments such as Title 20 supportive home care for services as appropriate. The screening interview was also used to tell private pay clients that they could waive the assessment and that they would have to pay a fee to cover the cost of any community services provided. In general, staff were satisfied with the rate at which they had been able to process referrals. They reported that they had usually been able to arrange the assessment for hospitalized clients within one to two days and that community referrals were not usually emergency situations so it was not necessary to act as quickly. Staff noted that they got fewer referrals from hospitals than expected and that in some cases hospital discharge workers notified them of potential clients but later follow-up regarding these persons showed they were private pay clients who decided to waive the assessment. In general they were surprised at how many people declined the assessment. They also reported that whereas they had expected to receive referrals of pending admissions from nursing homes, they, instead, had been contacted by nursing homes concerning current residents potentially able to live in a community setting. Because of this, Waupaca expected to change its plan of implementation for 1983 to start with nursing home waiting lists. They also wanted to begin implementing a waiver policy for private pay nursing home admissions/hospital discharges.

They also had not yet received any referrals having disabilities due to alcohol or other drug abuse whereas planning meetings with representatives of this disability group had led them to expect a number of referrals. They attributed the lack of referrals from out-of-county psychiatric hospitals to the unified services board policy of not using psychiatric hospitals for long term placements.

Overall, they were surprised at the number of referrals they got from doctors and nursing homes, at the young age of some of the persons referred, and at the severity of the medical and physical care needs of clients referred. Although they reported getting fewer referrals than the state expected them to receive, they noted that the referrals they got "kept them busy" and they expected it might be necessary to allocate more staff to case management when the program was fully implemented.

Assessment

Waupaca County's COP plan indicated hospitalized clients would be assessed by the hospital discharge planners but this policy was changed so that the COP coordinator and county nurse assessed these clients. The change was made because it was felt that the original arrangement led to duplication because the COP coordinator had to interview clients anyway in order to develop case plans.

The original allocation of staff to assess nursing home and out-of-county hospital referrals was also changed to include the county nurse. This change was made because it was felt that including the county nurse helped to ensure that clients who needed medical services but were not eligible for COP services would be immediately referred to receive medical services from other sources. Clients found ineligible during the assessment process were referred to other agencies for assistance. Agencies cited as receiving such referrals were supportive home care, public health nursing or adult family care. Table 16 summarizes the allocation of staff to do COP assessments.

TABLE 16

Waupaca County Allocation of Persons to Do Assessments

Referral Source	Assessment Personnel
1. Hospitals	COP coordinator and county nurse
2. Community referrals/developmentally disabled persons	Unified health service staff and county nurse and COP coordinator
3. Other community referrals	COP coordinator and county nurse
4. Nursing homes	COP coordinator, county nurse and facility-designated staff
5. State DD center	Unified health service staff and facility assessment team of a registered nurse and a social worker and COP coordinator
6. Psychiatric hospital	51.42 staff plus psychiatric hospital staff and COP coordinator

Waupaca County staff indicated they would like to modify their assessment tool for future use. In lieu of asking the questions stated, they used a conversational interview to obtain information about potentially embarrassing topics and reorganized the sequence of the items so that the assessment would be more like a conversation with the client. Staff indicated that repeated use of the tool and experience with working together had allowed them to refine the assessment process to the point where they and clients were generally comfortable with it. They felt that it was very important to have both a medically trained person and a social service representative assess the client jointly. Because the COP coordinator was involved in each of the assessments, they were confident that consistent procedures were being used to assess clients. They also noted that assessment of a hospitalized client was of limited value because it couldn't determine what the client would actually be able to do once he/she returned home and that they sometimes needed to do additional research such as talking to

neighbors or friends of a client after the assessment to find out what kind of services a client needed. They found clients sometimes said they could do things out of fear the county would force them to enter a nursing home.

Case Planning

Procedures

The COP coordinator was primarily responsible for preparing case plans for COP clients. In developing case plans, the COP coordinator met with the client, his/her family, hospital staff, significant others and assessors. The COP coordinator also had final authority for authorizing services in case plans. Case managers were selected based on the type of services the client was receiving. The agency providing most services to a client designated a staff person to be the client's case manager. If a client was developmentally disabled, the 51 board would be assigned to do case management for the client. COP clients receiving most of their services from the social service department would be assigned to the COP coordinator for case management services. In the initial months of project operation, county social services staff found it took considerable staff time to provide case management services for COP clients and they were therefore considering requesting additional staff to provide case management services. Case management services included counseling clients and their families, coordinating service delivery, and follow-up. Clients were contacted by phone at least monthly by the case manager and some were contacted more often (up to daily) depending upon their needs. The minimum amount of contact expected was a personal visit every six months. Once services were initiated for a client, they were only discontinued if the client requested it or if the client no longer needed services. They reported a few clients had been discontinued.

Policies

Payment for Services -- Under Waupaca County's COP, client income and assets were reviewed to determine if the client was eligible for cost sharing. Clients with income and assets above the amount allowed for Medicaid and also judged not likely to become eligible for Medicaid within six months if they did enter a nursing home were charged the full cost of services, including case management. Other clients -- those eligible for cost sharing - were asked to pay for only part of the actual cost of the community services provided to them. County staff reported adopting the cost sharing plan recommended by the state for COP because it took into account the special needs of COP clients. They felt the plan worked well and they had also adopted it for their Title 20 supportive home care program.

The type of funds used to pay the non-client share of the cost of community services varied according to the type of service provided. For adult family care, COP funds were used to pay the extra supplement. For supportive home care, if it was felt the client was headed for a nursing home, COP funds were used; otherwise, Title 20/Title III Aging funds were used. (Staff noted that in the future if they got a lot of expensive COP clients, they might change this policy, drawing $175 of the supportive home care costs from Title 20 funds and that it was not always clear which clients were actually headed for a nursing home. They noted that some clients who had considerable needs for care would not enter a nursing home because they were strongly against living in a nursing home.) For transportation, COP funds rather than Title III Aging funds were used.[1] For respite care, if the client was developmentally disabled, the 51 board was billed

[1] It was decided to use COP rather than Title III Aging monies for transportation because it was easier to manage.

for the cost of services. COP funds were also used to pay for the non-client share of health aid services for clients who were not eligible for Medicare or Medicaid and for case management services.

Ceiling on Diversion Services -- The Waupaca County Department of Social Services had not adopted any ceiling for the cost of COP-funded services to an individual client. For cases that were unusually expensive (i.e. $600/month), the coordinator would discuss it with the planning committee. They felt that if they got a lot of expensive cases in the future, they might have to establish a ceiling for community services per client.

Feasibility of Providing Services -- The feasibility of providing services to individual clients was determined based on client preferences and the availability of services. There was no upper limit on the amount of services. Staff reported only one case in which services were not provided because they were determined not to be feasible. In this case the client preferred nursing home care.

Selection of Service Providers -- Staff reported that because there were few agencies providing services in Waupaca County, they rarely were in the position of deciding which agency to obtain services from. The selection of service providers was the responsibility of the COP coordinator who noted that it was important to select providers based on a knowledge of client personalities. In the first months of project operation staff found that the type or amount of services being provided to many of the clients who had been receiving services for a few months had to be changed due to changes in client needs. Services reportedly had to be changed most often because clients released from hospitals who initially needed twenty-four hour care progressed so that they needed less service.

INDIRECT EFFECTS

Service Availability

Waupaca County staff reported that COP funds had not been used to develop any new services and, although some existing services had expanded recently, this wasn't due to the COP. The Waupaca County COP plan did not identify any services which they expected to develop or expand with COP funds; rather the plan indicated it was not the lead agency's intention to develop a number of new programs until they knew what the needs were. County staff felt that to operate the program in the future they would need more trained health aides and more staff to do case management/follow-up of COP clients. They also felt that they would contract with local nursing homes or Community Based Residential Facilities (CBRFs) to obtain in-home services for clients. (They felt that many of their clients were too sick to be transported to a nursing home/CBRF for services.)

Other Effects

Other effects related to implementing the COP mentioned by county staff were that it:

- o led to increased awareness of the need to serve the total person;
- o made the community realize the county social service department could serve more than just welfare clients;
- o fostered better cooperation between nursing home and hospital staff;

- fostered more communication between nurses and hospital discharge planners; and,

- encouraged nursing homes to expand the type of services available.

AGENCY VIEW OF INITIAL IMPLEMENTATION

Staff reported that one of the difficulties they encountered in initiating the program was trying to clarify who the program was to serve. They reported that originally they had felt the program was supposed to prevent people who might enter a nursing home in the future from deteriorating to the point where they would enter a nursing home. Thus they expected to be serving persons needing ICF 3-4 level of care. Later they came to understand it was to divert people who were currently headed to a nursing home, and thus persons needing SNF or ICF 1-2 care were the target group. It was felt that policy questions regarding the target group were still not completely resolved (some persons were questioning the wisdom of trying to replicate all of the services available in a nursing home in a person's own home) and that resolution of this issue was important because it affected the program's potential for cost savings or cost containment in the future. They also found that gradual implementation caused confusion if neighboring counties were not operating programs at the same time.

Another difficulty cited in the early stages of implementation was setting up policies/procedures for reporting and initiating services to clients. They felt that some of these difficulties could be resolved by setting up a master log of clients and filling out reporting forms at the same time an assessment or case plan was completed.

An area of program implementation which they felt worked especially well during the initiation of the program included the cooperation they had received from other agencies. They felt that program publicity and the efforts which had been made to individually contact other agencies helped develop agency cooperation and avoided the focus on potential problems which sometimes occurred in large group meetings.

They also felt that the team assessment approach they had adopted worked well.

Interorganizational Communication

County staff did feel that COP had fostered better relationships between the social services and medical communities. Communication between project staff and nursing homes and physicians was described as good. Nursing homes had reportedly been calling the COP staff before admitting patients and physicians had reportedly been making referrals to the program. Communication with hospital staff was also described as good, although the need to develop procedures for waivers was cited. Staff reported that they sometimes attended discharge planning meetings with hospital discharge planners and physicians.

In general they felt it was important to let the physician know what action the lead agency took regarding any persons referred by the physician. They also felt that it was important to have on-going communication with physicians and staff of nursing homes and hospitals.

Other agencies which the Waupaca County lead agency staff reported they contacted regarding operation of the Waupaca County COP included the community action program, which provided names of CETA workers who could provide services to clients; the commission on aging, which was developing a booklet describing local services; the Fox Valley Technical Institute, which offered to do training; and the local veterans' office, which initiated referrals and was coordinating the in-home services they provided with other in-home services provided to COP clients.

Adequacy of Services/Living Arrangements

Waupaca County staff felt that overall they had been able to obtain adequate community services for clients. They reported no problems in obtaining medical services for clients and only limited problems in obtaining social services for clients. They felt that if they could contract to obtain out-patient services from local nursing homes, some of these social service gaps would be diminished. Although most COP clients kept their original living arrangements, some problems were reported in providing for live-in assistance for clients in subsidized housing. These problems were subsequently resolved.

Potential for Program Growth

Staff reported that the type of client most likely to be served by COP was a person already receiving services to maintain community living who had some type of natural support system and did not need total care or supervision. They had found that persons with medical rather than emotional needs or physical handicaps were the easiest to serve. They found the most difficult clients to serve were those who were potentially a danger to themselves or others because there was a

lack of services and facilities (such as specialized adult family homes) for such persons. They felt that there were a lot of people in the county who could be diverted from nursing homes but were not sure if all of these persons would meet the COP target group definition. Their experience relative to serving private pay persons was that they usually declined to purchase case management services. Staff felt this was because private pay clients felt the $25/per hour service fee was too expensive.

In general, Waupaca County staff expected that referrals to their program would increase in the future -- especially in the winter months. This increase, however, was expected to be partially off-set by a decline in A.O. 1.67 referrals during the winter months.

IX. WINNEBAGO COUNTY

CONTEXT

Planning Activities

The Winnebago County COP Planning/Advisory Committee was appointed November 2, 1981. This committee included two consumers, a physician, and representatives from:

County Board of Supervisors
Theda Clark Regional Medical Center
Lutheran Homes of Oshkosh, Inc.
Visiting Nurses Association
Kimberly-Clark Corporation
Mercy Medical Center
Committee on Aging
51.42 Board

In addition, the planning process included the unified services board, the mental health clinic, the Winnebago County Nursing Service, Upjohn Healthcare Services, and the Lake Winnebago Health Systems Agency.

The planning committee was divided into two sub-committees: 1) inventory and assessment, and 2) services. These sub-committees conducted special surveys which examined the needs of the target population, the services available, the limitations in existing services, and the potential number of persons who would participate in the program. The COP plan for Winnebago County was submitted March 24th.

Lead Agency Role

The Winnebago County Department of Social Services (DSS) was designated the lead agency for COP. It was responsible for monitoring the costs of the program and for ensuring appropriate use of COP funds. DSS reviewed all assessments and

tentative case plans and was responsible for approving and authorizing the final service plan for all COP cases. DSS designated appropriate case managers, coordinated their efforts, and maintained files for each case plan. DSS also coordinated the billing of COP funds by service agencies.

Role of Other Agencies

Winnebago County public health nurses and the visiting nurses associations of Oshkosh and Neenah/Menasha assisted the DSS in conducting assessments. Two medical centers and the unified board/mental health clinic also conducted assessments. The hospitals began assessments in June.

Planning Committee Role

The planning committee was responsible for drafting a report to the social services board summarizing the progress of the county plan and the social services board was responsible for reporting to the county board of supervisors as necessary.

The planning committee developed policy. Program administration was left to the lead agency. The committee was considered advisory to the COP. The committee monitored the COP through periodic statistical reports from the lead agency. Respondents from the planning committee and the lead agency were satisfied with the functioning of the planning committee.

Eligibility Criteria

Persons were to be eligible to receive COP services if the assessment determined that they met the following criteria. (These criteria were also used in screening to determine if an assessment was indicated.):

a) Have a long-term or irreversible illness or disability.

b) Are seeking admission, about to be admitted, or are referred to a nursing home, DD center or other long-term care institutions; or are already residents of such facilities.

c) Are included within the county's plan for gradual implementation.

d) Require ongoing assistance to obtain or maintain stability and functioning.

e) Require some amount of medical, restorative or rehabilitative care.

Phase-in Plan

Winnebago County's plan did not give any specific target group priority on the basis of age or disability. The plan called for assessing sixty percent of all potential nursing home and long-term care institutional referrals in the first six months and phasing people into the program on the basis of referral source and pay status.

TABLE 17

Winnebago County Phase-In Plan

Referral Source	#	%	Expected Starting Month
Community			
1. MA eligible persons or those who would be in 6 mos.	234	52%	April
2. Nursing home residents A.O. 1.67 referrals	2	<1%	April
Hospitals (Theda Clark and Mercy Medical Center)	215	48%	
3. MA eligible persons			June
4. Persons who would be eligible in 6 mos.			August
Total	451	100%	

Residents of nursing homes were not scheduled for assessment until 1983. Referrals from state DD centers were to follow the schedule for community settings. Assessments of patients of psychiatric hospitals were not planned for 1982. Patients in the psychiatric units of Theda Clark and Mercy Medical Centers were to be assessed according to the schedule for those hospitals.

PROGRAM OPERATIONS

Intake Screening

Staff reported that all persons referred to the lead agency were assessed within the constraints of the phase-in plan. If existing services available in the community could meet the client's needs and COP funds were unnecessary, a referral to the lead agency was not made, and the assessment was not filed with DSS. Instead, the individual was referred to existing service agencies. There was a process for screening out ineligible persons prior to the assessment.

Winnebago staff reported they did not get as many referrals as they had projected. Their planning was based on estimated need from the health services agency, which resulted in over-projections of need. It was suggested that this over-projection was the result of the failure to take into account the levels of services already existing in the community.

Referrals were generally from the expected agencies and client categories.

Assessments

The lead agency gave assessing agencies the flexibility to employ their own assessment techniques. Therefore, there were a number of different assessment processes and tools employed in Winnebago County. For example, the Visiting Nurses Association of Oshkosh used an eight page assessment form developed for the project while the Visiting Nurses Association of Neenah/Menasha felt it already had sufficient information to identify most clients' needs and therefore only completed a partial PPOC and two 1-page forms.[1] The lead agency began using the eight page form, but later reduced the form to a "case plan page" which primarily recorded the client's service needs. There were also instructions for completing the "case plan page" which required that the client's needs were determined. It was felt that this process provided sufficient information to develop case plans.

Lead agency staff reported meeting with assessing agencies to ensure consistency.

Case Planning/Management

Procedures

Staff reported that if the client prefered community services, a tentative case plan was developed by the assessor. DSS approved and authorized the final case plan.

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[1] The PPOC is the MA Patient Medical Evaluation and Referral form described in chapter I.

DSS or a designated agency provided case management. The basis of case management designations was:

a) When only a DSS social worker was involved, that social worker was the case manager.

b) When more than one DSS social worker was involved, the unit supervisors and the social workers involved mutually decided upon a case manager. In instances where a decision could not be reached, the DSS program director named a case manager.

c) In cases of developmental disability, mental illness, alcoholism, and other drug abuse, the unified board or the mental health clinic was case manager, except in cases where:

   1) For protective services or guardianship and when more than minimal paperwork and legal services were requested, the DSS social worker was the case manager.

   2) For adults residing in adult foster homes, the DSS social worker was the case manager.

   3) If DSS had jurisdictional determination of a child, the DSS social worker was case manager.

d) For all other disabled persons, including the physically handicapped, DSS provided a case manager.

e) County nursing services and visiting nurse associations were the case managers for clients whose needs were provided solely by those agencies.

f) When DSS and other service providers are involved, DSS designated the case manager.

g) Hospital discharge planners did not serve as case managers.

DSS and the case manager were responsible for ensuring continuity in the treatment plan. The case manager informed all agencies involved as to the treatment plan and the responsibility of each agency within that plan. The manager changed the treatment plan as necessary and informed the involved agencies of the proposed changes to get their agreement. DSS approved any changes in case plans that required changes in COP service dollars.

The final responsibility for monitoring case plans rested with DSS.

Policies

Cost Sharing.--Winnebago County used the pilot cost sharing plan developed by the Wisconsin Department of Health and Social Services.

Reimbursement Policies.--Winnebago County did not charge the COP for case management in the initial months of project operation but was considering doing so for next year. However, they felt that given the maximum average cost limits, it may not be possible to charge the COP for this service.

Ceiling for Diversion Services.--Winnebago County set a $1,000 per client per month maximum in COP funds. This figure was set because it was roughly equivalent to the cost of a nursing home placement. Staff reported that no clients had been terminated because service costs exceeded the maximum.

Feasibility of Providing Services.--The assessor made the initial determination as to whether the referral could reasonably be served in the community.

In cases where community care seemed "possible," the assessor completed a draft case plan and sent it to the county social service department. There the case was assigned to a social worker who completed the case plan. The social worker then brought the completed case plan to his/her supervisor who made the financial decision regarding plan feasibility. There were no formal criteria (other than the dollar ceiling on services) for determining feasibility, either at the assessor or social worker supervisor level. Staff reported that no one had yet been terminated from the COP because services were determined not to be feasible.

Selection of Service Providers.--Where possible, clients were given a choice of service providers. This was not an explicit policy of the COP in Winnebago County, but it was the policy of the visiting nurses association and the county social service department.

INDIRECT EFFECTS

Expansion of Existing or Development of New Services

Staff reported that there were no new services created in Winnebago County that did not exist before the COP. However, training for providers of in-home services had expanded and some services were modified indirectly as a result of the COP. Adult day care, which was in a plan stage before COP, had been implemented by two agencies. A service directory was also published on a regular basis (new since COP).

Effect on Lead/Other Agencys' Operations

Staff reported an increase in caseload (and possibly an increase in the consumption of non-COP funded services) as a result of the COP in Winnebago County. As one result, the minimum age for clients in the older adults unit of the county social service department was changed from 60 to 65 years old and the maximum age for the younger adults unit was changed from 60 to 65 years.

It was also suggested that the COP resulted in more general acceptance (among agencies and the public) of home care as an alternative to institutionalization.

AGENCY VIEW OF INITIAL IMPLEMENTATION

Most Difficult/Best Aspects

One problem noted was that the COP in Winnebago County did not have one person who was a full-time coordinator, who could "master the guidelines" and be a consistent source of information to the wide variety of people working on the program. One person also noted that it would be beneficial, in terms of consistency, to have only one assessing agency. That person suggested that it might be more effective and efficient to have one or two specialists doing assessments, rather than several people in different agencies.

The COP staff felt that they were slower than they should have been in getting information to the general public.

There were complaints about the paperwork requirements imposed by the state. (The agency staff did not know why specific information was being collected and therefore tended to resent it.) One county staff person suggested that if you accept the premise that qualified people are running the program, reporting and paperwork could be eliminated.

The fiscal staff expressed a desire for clearer, more detailed guidelines in the area of fiscal accounting. They noted that central office staff was able to answer their questions, but there tended to be no documentation to support those answers.

Among the positive aspects of the program, staff noted that the COP caused the agency to develop a resource booklet that will increase the accessibility of services.

In Winnebago County the planning committee was divided into two specialized workgroups, one dealing with services and the other with assessments. It was felt that this division of labor worked very well.

Finally, there was an increase in knowledge and coordination among various agency staff. Nurses became more aware of social services and social workers learned about discharge planning, etc.

Communications Between Social/Medical Staff

The Winnebago County COP reportedly had very good relations with staff of hospitals in the area. The lead agency was working to improve relations with nursing home staff by making a presentation to county nursing home administrators at their bi-monthly meeting. They were working to improve communications with physicians by meeting with hospital medical staff.

Hospital representatives and a nursing home administrator were members of the planning committee. There were arrangements to have a physician on the committee.

Establishing relationships with physicians reportedly was difficult. It was suggested that counties initiating a COP spend time communicating to physicians early in the planning phase to promote their cooperation.

Adequacy of Services

Respondents felt that Winnebago County had outstanding social and medical services that were very adequately meeting needs.

Adequacy of Living Arrangements

Living arrangements were described as generally adequate, but a long waiting list for low-income housing in the Neenah/Menasha area and some limits on housing for the physically disabled in Oshkosh were also cited.

Potential for Program Growth

Two areas were mentioned for possible program growth. The first was among elderly persons who do not require twenty-four hour care and who have some family supports. The second was among terminally ill patients.

X. SUMMARY

County interviews provided considerable information on the initial implementation of Community Options Programs as well as information on county staff/representatives' attitudes toward the program.

PROGRAM OPERATIONS

Phase-In Plans

The complexity of the phase-in plans established by counties varied considerably. They ranged from plans such as Pepin County's (which indicated volunteers would be assessed first and then all Medicaid-eligible referrals) to very complex plans such as Rusk County's (which targeted referrals by location when referred, age, disability group and a variety of other factors such as diagnoses, number of hospitalizations in the last three months, etc.). Two of the counties (Portage and Racine) first took referrals from hospitals, one county (Dane) started with referrals from the community, and the other counties started their programs by accepting referrals from a variety of sources.

- Three of the eight counties reported that they got as many or more referrals than expected; the other five counties noted they got fewer referrals than expected. Two of these five counties (Waupaca and Racine) consequently revised their plan of gradual implementation in order to obtain more referrals.

- Counties did not always strictly follow their phase-in plans. Rather, referrals received from sources/groups not yet covered in their phase-in plans were sometimes assessed if they met other eligibility criteria for the program.

Eligibility Criteria

- Most counties adopted the definition for COP eligibility specified by state guidelines, but several added additional criteria to this definition.

- Two of the counties (Dane and Racine) reported that they had to revise their eligibility criteria during the first few months of project operation.

- Counties reported that the type of persons referred to their programs were generally in the age/disability groups from which they expected to receive referrals. Exceptions were: La Crosse which noted they received fewer referrals of elderly persons in nursing homes than they originally expected; Pepin, which reported that they got a wider variety of referrals than they originally expected; Portage, which noted that they were surprised at the extensiveness of the medical and social needs of the persons referred; and Waupaca, which noted they did not receive any referrals with alcohol or other drug abuse problems.

Assessment

- Only one of the counties was very satisfied with the assessment process they adopted initially. Five of the counties noted they had revised their assessment process during the first few months.

- The approaches used to conduct assessments ranged from a standard process in which the same assessment tool and the same staff were involved in each

assessment (Waupaca) to having different assessment tools and different staff and agencies be responsible for conducting the assessment (Winnebago).

- In two of the eight counties, more than one assessment form was used for COP assessments and several of the counties had staff from more than one agency conducting COP assessments.

Feasibility of Providing Services

- Only two of the eight counties (Portage and Racine) established other than financial criteria for determining the feasibility of providing services to individual clients. Both policies related to the need for twenty-four hour care.

- In most cases, the COP coordinator was responsible for determining if it was feasible to provide services to individual clients.

- At the time the interviews were conducted, staff reported no clients had been denied COP-funded services because it was judged not feasible to do so.

Ceiling on Diversion Services

- Three of the eight counties had established ceilings for the monthly cost of COP-funded services and one other county said it was considering doing so for 1983. (The ceilings ranged from $200/month to $1,000/month.) Two of the counties also noted that their COP planning committee reviewed unusually expensive cases.

- At the time staff/representatives were interviewed, no clients had been denied COP-funded services because they were too expensive.

Payment for Services

- Five of the eight counties elected to use the pilot cost sharing plan developed by the Wisconsin Department of Health and Social Services rather than the uniform fee system in the Administrative Code to charge COP clients for a portion of the costs of the services provided. In some cases, these counties also elected to use the pilot cost sharing plan to assess fees for other county programs such as Title 20 supportive home care.

- Of the three counties which did not adopt the pilot cost sharing plan, one charged clients nothing for their services, one charged clients the full cost until they were Medicaid eligible (at which point the client was charged nothing), and one expected to adopt some system of fees in the future.

- Counties established a variety of policies to determine funding sources to be used to pay for the non-client share of COP services. Policies often varied according to the type of client being served (i.e., clients new to the agency vs. those on the agency's caseload before being assessed by COP as well as by the type of service offered).

- Four of the eight counties always charged for the case management services provided to COP clients. One county charged for this service depending upon the other services the client was getting; the other three counties reported that they expected to start charging for case management in 1983.

Planning Committee Role

- Planning committees for all but two of the COP counties were described as advisory to the lead agency. Two counties reported that they felt decisions of the planning committee were directives to the lead agency.

- County staff/representatives were generally satisfied with the role planning committees had fulfilled during the initial months of program operation.

INDIRECT EFFECTS

Development of New Services

- Only one of the eight counties (La Crosse) cited new services developed as a result of the COP. A reason often cited for not developing new services was the lack of "up front" COP funding to do so.

Expansion of Existing Services

- Only two of the eight counties (La Crosse and Portage) noted that existing services had been expanded as a result of the COP. The small number of persons receiving COP-funded community services in the initial months of project operation was cited as a reason for not expanding existing services.

Effect on Lead Agency

- Only one of the counties reported that implementing the COP had led to changes in their lead agency's policies and procedures. (The change noted was a modified client billing system.)

- One county noted the program had resulted in a larger and older lead agency caseload.

- Most of the counties noted that COP had increased the workload in their agency and several cited problems with reporting requirements for the program. Other sources of problems noted were the fiscal reimbursement system, confusion as to who was eligible to be served by the program, the lack of lead planning time, the state guidelines, and the lack of full-time staff allocated to manage the COP at the county level.

- Several of the counties noted that operating the program had increased lead agency staff awareness of the COP target group and of the resources available to serve persons in the COP target group and that it also had increased inter-agency coordination.

AGENCY VIEW OF INITIAL IMPLEMENTATION

Adequacy of Services/Living Arrangements

- All of the county staff/representatives interviewed reported that they had generally been able to obtain adequate services for clients.

- Only two of the counties cited problems with available living arrangements for clients. (Problems noted included quality of housing and waiting lists.) One other county noted that locating adequate housing may become a problem when higher proportions of current nursing home residents were served by the program.

Communication with Hospitals, Nursing Homes and Client Physicians

- Staff/representatives of five of the eight counties reported that communication with nursing home staff was good to excellent. Of the other three counties, one noted nursing home staff was ambivalent toward the program; one reported that they were working on improving their communication with nursing home staff; and one said they had had trouble communicating with nursing home staff.

- Only three of the eight counties described communication with hospital staff as good to very good. Four of the counties described their communication with hospital staff as "just adequate," "O.K," "focusing on administrative issues," or "satisfactory." The eighth county noted that hospital staff were not referring clients to the program. Problems cited regarding the assessment of hospitalized clients ranged from administrative issues such as scheduling the assessment to issues regarding the methods used and the difficulties associated with predicting what the person could do in a community setting.

- Three of the counties described communication with physicians as "good"; two noted it was "O.K."; one noted they were working to improve communication with physicians; one county noted physicians were not referring clients to their program; and one county described communication with physicians as "not good."

- Only three of the eight counties reported good to adequate communication with all three groups (hospitals, nursing homes, and physicians).

PART II. PRELIMINARY EVALUATION FINDINGS

Included in this part of the report is:

- An evaluation of COP counties' efforts to target services to the type of clients described in the legislation and guidelines for the program;
- A description of the type, amount, and cost of services provided to clients;
- A description of the assistance given to clients by natural report systems;
- Findings from the survey conducted to determine the level of COP client satisfaction with community services; and
- Findings from the survey conducted to determine why some clients preferred nursing home care to community services; and
- Findings from the survey of client satisfaction with COP assessments.

Information presented in this section was obtained from COP county client reports, patient records from the Division of Health, the Department's Medicaid Management Information System, and client (phone) surveys. It should be noted that although county reports were edited and attempts were made to correct obvious inconsistencies, the accuracy of the data was not otherwise verified.

XI. TARGETING

REFERRALS

Age/Disability

COP counties reported receiving 592 referrals to their Community Options Programs in the first months of program operation. Most of the clients referred were elderly clients without categorical disabilities (CD) such as chronic mental illness or substance abuse (see table 18).

TABLE 18

Referrals by Age/Disability Group

Category	Number	%
Elderly w/o C.D.	432[a]	74%
Chronic Drug Abuse	3	<1
Developmentally Disabled (DD)	14	2
Chronically Mentally Ill (CMI)	1	<1
Physically Disabled	32	5
Combination of Above	105	18
Other (Brain Damaged)	1	<1
Total	588	100[b]
(Missing)	(4)	

[a] Most of the persons in this category were elderly with one or more categorical disabilties.
[b] Percentages do not add due to rounding.

La Crosse county was the only county which specified the proportion of categorically disabled clients they expected to assess. They expected that 60 percent of the clients they would assess would be categorically disabled. A slightly higher proportion of the clients referred to their program were categorically disabled.

TABLE 19

Categorically Disabled Referrals by County

County	%
Dane	45%
La Crosse	70
Pepin	17
Portage	17
Racine	39
Rusk	5
Waupaca	14
Winnebago	18
Total	26

TABLE 20

Referrals by County and Age/Disability Group

Age/Disability Group	Dane	La Crosse	Pepin	Portage	Racine	Rusk	Waupaca	Winnebago	Total
Elderly w/o C.D.	34	3	29	67	105	20	95	79	432
Chronic Drug Abuse	1		2						3
DD	1	1	2	4			5	1	14
CMI	1								1
Phys. Disabled	4	4	2	1	8		2	11	32
Combination of Above	20	2		9	59	1	9	5	105
Brain Damaged	1								1
Total	62	10	35	81	172	21	111	96	588
(Missing)	(1)	(1)	(1)	(1)	-		-	-	(4)

Racine County had the greatest number of referrals. The number of referrals per month of project operation ranged from 3.0 to 28.6. Table 21 presents the actual number of referrals to each county in comparison to the number of referrals or assessments their Community Options Program plans indicated they expected to receive in calendar year (CY) 1982.[1]

[1] Half of the counties did not indicate how many referrals they expected to receive but they did indicate how many assessments they would do.

As table 21 indicates, counties will probably assess less than 1,000 clients in 1982. In comparison, the money allocated for assessments was enough to assess 3,534 clients in 1982. The lower than expected number of referrals was possibly related to the slower than anticipated initiation of most of the programs.

TABLE 21

Referrals Per Month by County

County	Program Start Date	Months of Operation	Total Referrals	Referrals Per Month	Estimated CY Total[a]	Total Expected From Plan Assmts.	Referrals
Dane	5/10	4.5	63	14.0	105	555	
La Crosse	8/1	2.0	11	5.5	28		60-80
Pepin	3/15	6.5	36	5.5	53		50
Portage	4/1	6.0	82	13.7	123		157
Racine	4/1	6.0	172	28.6	258	425	
Rusk	3/1	7.0	21	3.0	30	93	
Waupaca	2/2	8.0	111	13.9	153		192
Winnebago	4/15	5.5	96	17.5	149	451	
Total			592		899		

[a] Estimated CY total = balance as of 9/30 plus 3 (Referrals/mo). Because the number of referrals increased slightly over time, if only August and September are used to calculate the average number of referrals per month, the estimated CY total also increases slightly -- to 931 referrals.

Location of Persons Referred

Approximately half of the persons referred were in a hospital at the time they were referred.[1]

[1] In this discussion psychiatric hospitals are excluded from the general term "hospital." See table 22.

TABLE 22

Referrals by Location When Referred

Location When Referred	Referrals Number	%
Nursing Home	54	9%
DD Center	1	<1
Hospital, Not Psych.	301	51
Psych. Hospital	1	<1
CBRF or Group Home	3	<1
Adult Family Home	4	<1
Own Home	188	32
Other	40	7
Total	592	100[a]

[a] Percentages do not add due to rounding.

For only three of the counties (La Crosse, Pepin and Portage) was the proportion of referrals from hospitals close to what their COP plans indicated they expected (see table 23).

TABLE 23

Number of Referrals by Location When Referred and County

Location When Referred	County								
	Dane	La Crosse	Pepin	Portage	Racine	Rusk	Waupaca	Winnebago	Total
Nursing Home	15	3	11	4	8	1	9	3	54
DD Center		1							1
Hospital, Not Psych.	4	1	11	46	146	18	61	14	301
Psych. Hosp.	1								1
CBRF or Group Home			1		1		1		3
Adult Family Home	1	1	1	1					4
Own Home	39	3	9	21	9	2	30	75	188
Other	3	2	3	10	8		10	4	40
Total	63	11	36	82	172	21	111	96	592
Actual % from Hosp.	6%	9%	31%	56%	85%	86%	55%	15%	51%
Expected % From Hosp.[a]	45%	16%	40%	52%	42%	NS[b]	79%	48%	

[a] Expected percent is based on the percentage of referrals or assessments of hospitalized clients stated in COP county COP plans.

[b] NS = not specified.

Action Regarding Referrals

As table 24 indicates, all but 35 percent of the persons referred were assessed.

TABLE 24

Referrals by County Action

County Action	Number	Percent
1. Referred but Not Assessed	208	35%
2. Assessed, but No Case Plan Developed	221	37
3. Assessed and Case Plan Developed, but Services Not Provided	23[a]	4
4. Assessed, Case Plan Developed, and Community Services Provided	140	24
Total	592	100

[a] County reports indicated that they intended to begin serving 12 of these clients after September 30th.

Six of the clients who were assessed were assessed twice by September 30th. Of these clients, three were reassessed in two months; two were reassessed in three months; and one was reassessed four months after the initial assessment. Table 25 presents the referrals to each county by the action taken concerning the referral.

TABLE 25

Referrals by County Action and County

County	County Action: Just Referred	Just Assessed	Case Plan, Not Served	Served	Total
1. Dane	18	22	1	22	63
2. La Crosse	6	2	0	3	11
3. Pepin	12	13	1	10	36
4. Portage	15	50	3	14	82
5. Racine	61	74	8	29	172
6. Rusk	19	0	0	2	21
7. Waupaca	59	23	3	26	111
8. Winnebago	18	37	7	34	96
Total	208	221	23[a]	140[b]	592

[a] 12 to be served after 9/30/82.
[b] Includes private pay. COP-funded equalled 92.

Persons Referred But Not Assessed

Over 80 percent of the 208 persons who were referred but not assessed were elderly without categorical disabilities.

TABLE 26

Persons Not Assessed by Age/Disability and County

Age/Disability	County: Dane	La Crosse	Pepin	Portage	Racine	Rusk	Waupaca	Winnebago	Total
Elderly w/o CD	13	2	11	12	45	18	54	14	169
Drug Abuse	1								1
DD							3		3
CMI	1								1
Physically Disabled		3		1	2			4	10
Combination of Above	3			2	14	1	2		22
Total	18	5	11	15	61	19	59	18	206
(Missing)		(1)	(1)						(2)

Reasons for Not Assessing Clients

In approximately half of the cases, the reported reason for not assessing clients referred to the program was that the person declined the assessment. Clients declining the assessment was the most frequent reason for not assessing clients in Dane, Pepin, Racine and Waupaca counties. The most frequently reported reason for not assessing clients in the remaining four counties was that the person was not in the target group (see table 27).

TABLE 27

Percent of Persons Referred Who Were Not Assessed by County and Reason Not Assessed

Reason Not Assessed	County								Total	
	Dane	La Crosse	Pepin	Portage	Racine	Rusk	Waupaca	Winnebago	#	%
Did Not Meet Target Group Definition	5.6%	66.7%	16.7%	46.7%		47.4%	15.3%	55.6%	42	20.2%
Not Covered in Phase-In Plan	11.1			26.7			1.7	16.7	10	4.8
Declined Assessment	50.0	16.7	41.7	13.3	96.7	10.5	50.8		108	51.9
Could Not be Assessed Before Plcmt Action Needed	16.7	16.7	25.0	6.7		5.3	6.8		13	6.3
Found Own Services							6.8		4	1.9
Family Declined							8.5		5	2.4
Died	5.6		8.3	6.7		5.3	3.4	11.1	8	3.8
Assessed After 9/30	5.6							5.2	2	1.0
Other[a]	5.6		8.3		1.6	31.6	6.8	11.1	16	7.2
Not Reported					1.6				1	0.5
Total	100	100	100	100	100	100	100	100	208	100

[a] Other includes: Went to out-of-county hospital (1), Unable to understand program (1), Went to nursing home (1), Comatose (2), Hospital didn't inform County of discharge (1), Assessing agency decided services adequate without COP (1), Re-admitted to hospital before assessment complete (1), Court ordered to nursing home (1), Took action without notifying (1), Protective Placement in nursing home needed (3), Does not meet COP Guidelines (1), In hospital beyond 15 days (1), and returned home (1). The total (16) included 1 client for whom 2 reasons were stated.

CLIENTS ASSESSED

Age

Based on data reported for 273 clients the average age of the 384 persons who were assessed was 75.9 years. There was considerable variation in the ages of the clients assessed in La Crosse, the county which assessed the youngest client group in comparison to the other counties.

TABLE 28

Clients Assessed by Age at Assessment and County

County	# Reported on	Missing	Age			Total Assessed
			Average	Std. Dv.	Coefficient of Variation[a]	
1. Dane	35	10	77.81	18.10	24%	45
2. La Crosse	5	0	33.06	29.40	89%	5
3. Pepin	18	6	70.17	18.89	27%	24
4. Portage	30	37	76.41	15.63	20%	67
5. Racine	88	23	78.33	15.21	19%	111
6. Rusk	2	0	75.38	11.61	15%	2
7. Waupaca	41	11	71.53	21.35	30%	52
8. Winnebago	54	24	79.59	12.23	15%	78
Total	273	111	75.88	17.79		384

[a] Coefficient = 100 (std. dv./ave.).

Level of Care

It was possible to obtain a rating of the level of care designation for only 249 (65 percent) of the 384 persons who were assessed.[1] Over half of these ratings were obtained from partially completed PPOC forms which were prepared for the purposes of this report; almost two-thirds of the forms prepared for this

[1] Reasons why PPOC forms were not obtained in the remaining cases were 1) private pay client entered nursing home and record was not accessible/comparable (40%), 2) county failed to complete report for person not entering a nursing home (5%), 3) client died (4%) and 4) record could not be retrieved in time to be included in report (51%).

evaluation were prepared without the involvement of a physician. (Counties had the option of having either a nurse or a physician prepare the PPOC form whereas physicians are always involved in preparing PPOC forms for Medicaid admissions to nursing homes.)

As table 29 illustrates, higher proportions of the persons for whom complete PPOC reports were obtained were evaluated as needing skilled care or ICF-1 intermediate care. All of the clients evaluated as needing ICF-4 care and all but one of those who were evaluated as needing ICF-3 care were clients for whom partial PPOC forms had been obtained.[1]

TABLE 29

Persons Assessed by Level of Care and Type of PPOC

Level of Care[a]	Complete (Retrieved From District Office)		Partial (Prepared for Evaluation Only)		Total		
	#	%	#	%	#	%	Cumulative %
SNF	82	79%	31	21%	113	45%	45%
ICF 1	18	17	55	38	73	29	74
ICF 2	3	3	32	22	35	14	88
ICF 3	1	1	23	16	24	10	98
ICF 4	0	-	2	1	2	1	99
<ICF 4	0	-	2	1	2	1	100
Total	104	100	145	100[b]	249	100	
(Missing)					(135)	(35%)	

[a] Level of care definitions are described in appendix D.
[b] Percentages do not add due to rounding.

[1] See appendix D for a description of each of the care levels.

Overall, the PPOC forms which were obtained suggested that almost three-fourths of the clients assessed were at the skilled (SNF) or intermediate (ICF-1) care levels. In comparison, 93 percent of the admissions to the nursing homes in the eight volunteer counties in 1981 were at these (SNF, ICF-1) care levels. Racine and Pepin counties had the largest proportion of clients assessed who were rated as being at the SNF or ICF-1 care levels.

TABLE 30

Percent of Cases Assessed by Level of Care Designation and County (N=249)

Level of Care	Dane	La Crosse	Pepin	Portage	Racine	Rusk	Waupaca	Winnebago
SNF	29%	80%	59%	40%	64%		18%	35%
ICF 1	14		29	23	30	50%	41	28
ICF 2	14			26			33	21
ICF 3	29	20	12	11	3	50	8	14
ICF 4	14							2
<ICF 4					2			
Total	100	100	100	100	100[a]	100	100	100
(# of Cases)	(7)	(5)	(17)	(35)	(87)	(2)	(39)	(57)
% Cases Reported	16	100	71	52	78	100	75	73

[a] Percent does not add due to rounding.

Pay Status

Counties reported the pay status of 379 (99 percent) of the 384 persons who were assessed (see Table 31).

TABLE 31

Persons Assessed by County-Reported Pay Status and County

County	MA Eligible	Expected to be Eligible in 6 Months[a]	Private Pay	Total
Dane	14	8	20	42
La Crosse	3	2		5
Pepin	14	5	4	23
Portage	21	13	33	67
Racine	73	19	19	111
Rusk	2			2
Waupaca	23	13	16	52
Winnebago	20	51	6	77
Total	170	111	98	379
Pct. of Total	45%	29	26	100

[a] Figures in this column represent county staff estimates, at the time of assessment, as to what would occur in the future.

The county reports suggested that 74 percent of the clients assessed were eligible for Medicaid or would become eligible within six months. To verify the incidence of Medicaid-eligible and potentially Medicaid-eligible clients, a second source of information, the Department's Medicaid Management Information System, was used. Because persons could be retroactively certified Medicaid-eligible for a period of up to six months, records of the 100 persons assessed through May were checked after December 1. This analysis showed the incidence of Medicaid-eligible and potentially Medicaid-eligible assessments to be 48 percent rather than the 74 percent estimated by the counties.

TABLE 32

Pay Status of Clients Assessed Through May of 1982 as of December of 1982 (MMIS Data)

Status	Number
Certified MA Eligible at Time Assessed	36
Certified MA Eligible Within 6 Months of Assessment	12
Not Certified MA Eligible Within 6 Months of Assessment	52
Total	100

This analysis also showed considerable variability in the Medicaid eligibility status of the clients assessed. A number of the clients lost eligibility for periods of time or became ineligible and were not recertified during the time period analyzed (assessment plus six months). This variability undoubtedly contributed to differences in the incidences obtained from county versus MMIS data.

Reasons for Not Developing Case Plans

Case plans were not developed for 221 (58 percent) of the 384 persons who were assessed. The most frequent reason for not developing a case plan (reported by counties) was that the person preferred nursing home care. (This was reported for 109 cases).[1] The other reasons which counties reported for not developing case plans for clients assessed were:

[1] A survey of responses in this category appears in chapter XIII of this report.

- o Guardian preferred nursing home care (18),
- o Patient not interested (13),
- o Insufficient program or program openings (10),
- o Family not interested (9),
- o Insufficient funds to provide community services (9),
- o Family preferred nursing home (9),
- o Person needs skilled care (6),
- o Not COP eligible/not in target group (8),
- o Person died (7),
- o Person found own services (5),
- o Doctors recommended nursing home (3),
- o Family unable to provide care/supervision (2),
- o Patient hospitalized (2),
- o Ineligible over assets (2),
- o Family withdrew request (1),
- o Referred to supportive home care (1),
- o Preferred another county's nursing home (1),
- o Home situation inappropriate (1),
- o Preferred CBRF (1),
- o Awaiting appeal (1),
- o Not willing to cost share (1),
- o Insufficient funds to develop case plans (1), and
- o Other (not specified.).

Of the clients for whom case plans were not developed, the level of care was reported for 125 (57 percent). Reported levels were: SNF (64 percent), ICF-1 (22 percent), ICF-2 (8 percent), ICF-3 (5 percent), and ICF-4 (less than 1 percent).

CASE PLANS

Case Plan Clients

Case plans were developed for 163 persons. Over 60 percent of the persons for whom case plans were developed were evaluated as needing skilled (SNF) or intermediate (ICF-1) care.

TABLE 33

Clients for Whom Case Plans Were Developed by Level of Care Designation

Level of Care	Number	%	Cumulative %
Skilled	33	27%	27%
ICF 1	45	37	64
ICF 2	23	19	83
ICF 3	17	14	97
ICF 4	1	1	98
<ICF 4	2	2	100
Total	121	100	
(Missing)	(42)		

Case Plan Services

Case plans included COP-funded services as well as services from other funding sources such as Title 20, Title III, and Medicaid.

The number of separate services included in case plans appeared to decline as the level of care declined, although there were too few cases at the lower levels of care to adequately test this relationship.

TABLE 34

Number of Services in Case Plans by Client Level of Care

Level of Care	Number of Cases	Number of Services[a] Average	Std. Dv.
SNF	33	3.5	1.6
ICF 1	45	3.3	1.7
ICF 2	23	3.3	1.5
ICF 3	17	3.2	1.5
ICF 4	1	1.0	0
<ICF 4	2	1.0	0
Total	121	3.3	
(Missing)	(42)		

[a] Reflects COP-funded services as well as services funded from other sources.

The number of services in case plans varied by county. Pepin and Dane had the greatest number of services in case plans.

TABLE 35

Average Number of Services in Case Plans Per County

County	Cases Reported	Number of Services[b] Average	Std. Dv.	Coefficient of Variation[a]
Dane	23	5.6	2.8	50%
La Crosse	3	2.0	1.0	50%
Pepin	11	6.0	1.7	28%
Portage	16	2.3	0.6	26%
Racine	37	2.7	1.1	41%
Rusk	2	2.5	0.7	28%
Waupaca	28	3.4	1.1	32%
Winnebago	40	3.7	1.7	46%
Total	160	3.6	2.0	55%
(Missing)	(3)			

[a] Coefficient = 100 (std. dv./ave.).
[b] The number of services reflects COP-funded services as well as services provided with other funds.

COP-Funded Services

Supportive home care was clearly the service most often selected to be funded with COP monies (see table 36).

TABLE 36

Case Plan COP-Funded Services by Number of Clients and COP Funds Per Month

Service Type[a]	Cases Reported	Aggregate COP Funds Per Month
Adult Day Care	4	$ 593.80
Respite Care	6	435.00
Supportive Home Care	85	21,527.00
Specialized Transp./Escort	6	179.30
Adult Family Home	1	75.00
Foster Home (Child)	1	319.00
Group Home (Not CBRF)	1	350.00
Congregate Meals/Nutrition Ed	1	25.00
Home Delivered Meals	3	142.32
Community Based Treatment Facility	2	204.50
Day Service/Treatment	1	353.00
Case Management	60	4,107.29
Placement Assistance and Monitoring	17	790.50
Manpower Training and Development	17	204.00
Agency/Systems Management	17	472.00
Home Health Aide/Private Nursing	8	5,164.04
Drugs	3	150.00
Other	2	230.00

[a] Appendix E contains definitions of these services.

Reasons for Not Implementing Case Plans

In over half of the few (23) instances in which case plans were develped but not implemented by September 30th, county reports indicated that the client would receive services after September 30th. In 6 of the remaining 11 cases, the county reported the reason for not implementing the case plan. Reported reasons were that:

- There were insufficient funds to develop community alternatives (1),
- The person preferred nursing home care (3), or
- The person had to be hospitalized (2).

Counties also reported that two of the persons who preferred nursing home care subsequently entered a nursing home and that one entered a DD center.

Over half of the 23 persons for whom case plans were not implemented by September 30th were elderly clients without categorical disabilities.

SERVICE CLIENTS

Level of Care

Approximately 62 percent of the persons reported to receive community services were rated as needing skilled (SNF) or intermediate (ICF 1) care. Pepin and Racine had the highest proportion of COP service clients at the SNF through ICF-1 care levels. Level of care designations were not reported for any of the clients served in Dane County.

In comparison, 74 percent of those assessed and 64 percent of those for whom case plans were prepared were rated as needing SNF or ICF-1 care. This suggests that persons with greater service needs tended to drop out at both the case plan and service delivery phases of program operation. Differences may have been influenced by the small number of cases reported on.

TABLE 37

Percent of Clients Receiving Community Services by Level of Care

	County								
Level of Care	Dane	La Crosse	Pepin	Portage	Racine	Rusk	Waupaca	Winnebago	Total
SNF		66.7%	33.3%	35.7%	36.0%		8.7%	18.8%	24.8%
ICF 1			50.0	7.1	48.0	50.0%	52.2	31.3	37.1
ICF 2				35.7			30.4	34.4	21.9
ICF 3		33.3	16.7	21.4	8.0	50.0	8.7	15.6	14.3
ICF 4									
<ICF 4					8.0				1.9
Total	0	100	100	100	100	100	100	100	100
Cases Reported		3	6	14	25	2	23	32	105
(Missing)	(22)	(0)	(4)	(0)	(4)	(0)	(3)	(2)	(35)

Age/Disability

The average age of the clients served was 74.2 years at the time they were assessed.[1] Approximately 68 percent of the clients receiving community services were elderly clients without categorical disabilities. Thus elderly clients without categorical disabilities were a smaller proportion of the group of clients receiving services than would be expected based on the proportion of elderly clients without categorical disabilities in the initial population of clients referred. (Seventy-four percent of the clients referred were elderly without categorical disabilities.)

[1] The average age was computed based on 127 (or 91 percent) of the 140 clients receiving community services.

TABLE 38

Percent of Clients Receiving Community Services by Age/Disability Group and County

Age/Disability	Dane	La Crosse	Pepin	Portage	Racine	Rusk	Waupaca	Winnebago	Total
Elderly W/O CD	45.5%	33.3%	60.0%	85.7%	55.2%	100%	73.1%	85.3%	67.9%
Chronic Drug Abuse			20.0						1.4
DD	4.5		10.0	7.1			7.7	2.9	4.3
Physically Disabled	4.5	33.3	10.0		13.8		3.8	5.9	7.1
Combination of Above	40.9	33.3		7.1	31.0		15.4	5.9	18.6
Brain Damaged	4.5								0.7
Total	100	100	100	100	100	100	100	100	100
Cases Reported	22	3	10	14	29	2	26	34	140

Other Characteristics

Sixty-one percent of the clients served were female and fifty percent were widowed. The marital status of the remaining clients was: married (37 percent), single (10 percent), divorced (2 percent), and separated (1 percent).[1]

Only six of the clients who received community services were in a nursing home when they were assessed. By September 30th, only two of these clients remained on COP county caseloads. One of these four clients was deceased and no COP funds were used to provide community services to the other three clients.

[1] Client sex was reported for 127 (91 percent) of the 140 clients served and marital status was reported for 119 (85 percent) of the clients served.

XII. SERVICES PROVIDED

SERVICE PERIOD

Counties reported that COP funds were used to provide services to 92 (65 percent) of the 140 persons who received community services by September 30th.

By September 30th, 23 of the 92 COP-funded service clients as well as 46 of the other 48 clients receiving community services from non-COP funding sources were terminated from the COP caseload. In most cases, COP counties automatically terminated clients from the COP caseload if the client would not be receiving any COP-funded services.[1] Table 39 presents the reasons why the 69 clients who were terminated from the COP program caseload by September 30t were so terminated.

TABLE 39

Reasons For Terminating Clients From the COP Casload

Reasons for Terminating Clients	Number Terminated		
	COP Funcd	Other	Total
Not using COP service dollars		40	40
Private pay, not interested in case management		3	3
Chose not to disclose financial status		2	2
Went to nursing home	8	--	8
Moved out of county	1	--	1
Client's request	2	--	2
Health situation changed	2	--	2
Other	2	--	2
Deceased	8	1	9
Total	23	46	69

[1] For the purposes of state reporting requirements, when a peon no longer receives COP-funded services, he or she is considered to be erminated from COP. He or she may, however, continue to receive communityervices from other funding sources.

Time To Termination

Six of the COP-funded service clients who were dropped from the program by September 30th were dropped in the same month COP-funded services were initiated, and seven stopped being served in the month following the month services were initiated.

TABLE 40

Months of Services Provided to COP-Funded
Service Clients Terminated by September 30th

Month Services Started	Month Terminated								
	March	April	May	June	July	August	September	October	Total
February	1								1
March		2							2
April		1	1						2
May				3	1	1			5
June				4				1	5
July						2	1	1	4
August						1	3		4
Total	1	3	1	7	1	4	4	2	23

At the time counties reported, most of the clients receiving COP-funded services had been receiving services for a little over two months. Racine, which was the only COP county adapting an assessment process previously used in their county, provided the most days of service. The days of service provided to clients (presented in table 41) was calculated based on the days of service provided to each client by September 30th or by the date he/she was terminated from the program. County reports included the date on which clients began to receive community services.

TABLE 41

Days of Service Provided to COP-Funded Service Clients By September 30th

County	Program Start Date	Cases Reported	Days of Service Per Client Average	Days of Service Per Client Standard dv.
Dane	5/10	15	40.6	37.9
La Crosse	8/1	3	22.3	6.1
Pepin	3/15	6	72.3	68.6
Portage	4/1	11	64.6	36.7
Racine	4/1	12	91.9	46.7
Rusk	3/1	0	--	--
Waupaca	2/2	23	65.6	42.4
Winnebago	4/15	18	75.9	45.8
Total	--	88	65.9	45.7
(Missing)[a]		(4)		

[a]Two of the missing cases were from Dane County and two were from Racine County.

COST OF SERVICES

COP Costs

Counties reported spending only $56,043 (COP funds) to serve 88 of the 92 clients who they reported received COP-funded services by September 30th. (For the other four clients, counties reported that they had used COP funds--they did not report the amount spent.) In comparison, the total amount of service money (COP funds) allocated for 1982 (twelve months) was $649,200, which if adjusted to reflect the number of months of actual program operation in each of the counties, would be $279,750.29.[1]

[1] Adjustment = (months of operation per county/12) (county allocation). In addition to delayed program operation, less than anticipated expenditures may have also been related to lower than expected COP expenditures per client per month and to the fact that some of the COP-funded service clients were terminated from the program after a few months of service.

TABLE 42

COP Dollars Spent By September 30th By County

County	Program Start Date	Mos. of Op.	Cases Reported	Total[a]	YTD Average Per Client	County Service Allocation for CY
Dane	5/10	4.5	15	$ 4,496.79	$ 299.79	$205,511.00
La Crosse	8/1	2.0	3	498.36	166.12	$ 68,153.00
Pepin	3/15	6.5	6	2,936.76	498.46	$ 8,900.00
Portage	4/1	6.0	11	4,215.15	383.20	$ 49,183.00
Racine	4/1	6.0	12	13,922.00	1,160.17	$155,977.00
Rusk	3/1	7.0	--	--	--	$ 16,860.00
Waupaca	2/2	8.0	23	13,153.49	571.89	$ 37,472.00
Winnebago	4/15	5.5	18	16,820.93	934.50	$107,144.00
Total	--		88	56,043.48	636.86	$649,200.00
(Missing)			(4)[b]			

[a]Source: COP Service Report, page 2.
[b]Two of the missing cases were from Dane County and 2 were from Racine County.

COP Costs Per Day of Service

For comparison purposes, the COP costs for each client were divided by the days of service provided to the client by September 30th, or by the date when he/she stopped receiving services. Table 43, which presents the findings, suggests that the average amount of COP money was $11.51 per day of service. This would be $349.90 a month. In comparison, counties were to spend no more than an average of $400 per month for clients receiving COP-funded services. As table 43 illustrates, the COP costs/day varied considerably by county and within the counties.

TABLE 43

COP Funding By Cost Per Day of Service and County

	Cases Reported	Monthly Cost[a]	Cost Per Day of Service[b] Average	Standard dv.	Coefficient of Variation
Dane	15	$399.46	$13.17	$13.02	99%
La Crosse	3	262.05	8.62	8.79	102%
Pepin	6	268.13	8.82	4.60	52%
Portage	11	153.22	5.04	5.65	112%
Racine	12	382.13	12.57	5.34	42%
Rusk	--		--	--	--
Waupaca	23	331.97	10.92	6.73	62%
Winnebago	18	471.50	15.51	12.40	80%
Total	88	349.90	11.51	9.44	83%
(Missing)	(4)[c]				

[a]Monthly cost = 30.4 (cost per day)
[b]Source: COP Service Reports, page 2.
[c]Two of the missing cases were from Dane County and two were from Racine County.

Total Costs

COP counties reported the total costs of all the services provided to clients for only half (46) of the 92 clients receiving COP-funded services. (Total costs include other funding sources such as Title 20, Title III, and Medicaid.) The small number of reports suggest that monies from other funding sources may represent 40 percent of the total costs of providing community services. However, counties were generally unable to report the cost of medical services provided to clients; it is likely, therefore, that other funding sources contribute more than 40 percent of the total cost (see table 44).

TABLE 44

Relationship of COP to Other Funding Sources

Funding Source	Reported Cases	Missing[a]	Percent of Total Costs
COP	92	0	58.0%
MTA	92	0	12.0
Title III	90	2	3.0
Private Payments	91	1	11.0
Medicaid	78	14	4.5
Medicare	59	33	3.5
HUD, Section 8	92	0	7.0
Other	92	0	1.0
Total	46	46	100.0

[a]Missing equals those for whom expenditures were made, but the county did not specify the amount.

NUMBER AND TYPE OF SERVICES

On average, four different services were provided to maintain clients receiving COP-funded services in the community. The number of services provided includes services provided from funding sources other than COP.

TABLE 45

Average Number of Services Provided To Clients Who Received COP-Funded Services

County	Cases Reported	Number of Services		Coefficient of Variation[a]
		Average	Standard dv.	
Dane	17	4.6	0.9	20%
La Crosse	3	1.3	0.6	46%
Pepin	6	5.2	1.8	35%
Portage	11	2.6	0.5	19%
Racine	14	3.7	0.8	22%
Rusk	--	--	--	--
Waupaca	23	4.2	1.5	36%
Winnebago	17	4.5	1.6	36%
Total	91	4.0	1.5	38%
(Missing)[b]	(1)			

[a]Coefficient = 100 (std. dv./ave.)
[b]The one missing case was from Winnebago County.

The most common use of COP funds was to provide supportive home care. Home health services and case management services were also frequently funded with COP dollars.

TABLE 46

COP-Funded Services By Number of Clients and Percent of Funds Spent Per September 30th

Service Type	Cases Reported	Percent of Funds Spent Per Sept. 30th
Adult Day Care	2	< 0.1%
Respite Care	5	0.2
Supportive Home Care	76	65.8
Specialized Transport & Escort	10	0.2
Foster Home (Child)	1	0.6
Home Delivered Meals	11	0.5
Community Based Treatment Facility	4	1.1
Day Services/Treatment	1	0.5
Case Mgt./Service Coordination	87	8.2
Placement Assistance & Monitoring	15	1.8
Manpower Training & Development	17	0.7
Agency/Systems Management	31	5.1
Home Health Aide/Private Nurse	44	14.5
Drugs	13	0.7
Total	92	100%

[a] Appendix E contains a description of these services

Services Provided From Other Sources

Public Services

In addition to the COP-funded services, clients who received COP-funded services also received a number of other services from other funding sources. The types of services reported included:

Community Support
Adult Family Home
Congregate Meals/Nutrition Education
Counseling/Therapeutic Resources
Information & Referral
Therapy (Physical Therapy, Occupational Therapy, Speech, etc.)
Physician Services
Dental Care
Hospitalization
Other Medicaid Services

NATURAL SUPPORTS

Clients receiving COP-funded services also received assistance from natural supports: friends, neighbors, or relatives. The types of assistance provided by natural support systems is shown in table 47.

TABLE 47

Clients Receiving COP-Funded Services By
Type of Services Received From Natural Supports

Type of Service	Number of Clients Receiving Service
Medically-related care, N.S.[a]	6
Assist with medications	1
Assist with medical therapy such respiratory therapy	2
Personal care, NS	23
Assist with all activities of daily living (ADLS)	2
Selected Housekeeping, NS	31
Cooking	3
Cleaning House	3
Shopping	13
Laundry	4
Lawn care	1
Run Errands	1
Housekeeping - total care of house	3
Selected Miscellaneous	33
Managing money[b]	14
Transportation[b]	11
Respite Care[b]	9
Recreation/social (visit or call person)[b]	26
Supervision	7
Legal Needs	3
Social Outings	2
Miscellaneous - all	3

[a]NS = not specified.

[b]The category of miscellaneous included these items.

XIII. CLIENT SURVEYS

INTRODUCTION

One of the unique features of the COP is that it gives clients a choice between entering (or remaining in) a nursing home/DD center or living in a non-institutional setting with the aid of community-based services. It is generally assumed that, given this option, the overwhelming majority of the clients would choose the non-institutional setting.

However, according to the assessment reports submitted by COP lead agencies, approximately 58 percent of the persons assessed by the COP did not receive case plans. And, in 57 percent of those cases, the county agency reported that the reason why a case plan was not developed was because the person entered a nursing home because the client or the client's guardian preferred nursing home care.

The interpretation of these reports took into account that the agency could have checked a number of other possible reasons for not developing a case plan including:

- insufficient funds to develop case plan,
- insufficient funds to provide the community alternatives,
- insufficient program or program openings, or
- other.

It was decided to conduct a telephone survey of those persons who reported turning down the community option because they or their guardians preferred nursing home care to determine the reasons for their choice. It was believed that a description of the reasons for rejecting the COP could provide insight into the dynamics that lead to institutionalization, identify areas in which the program might be changed to better meet clients' needs and provide a measure of the feasibility of using community-based services to meet the expressed needs of persons bound for institutional care.

There was also interest in how satisfied persons were with various aspects of the COP, including the services delivered. Therefore, a second telephone survey was conducted with persons who accepted and received COP services to determine their satisfaction with the services provided.

Both surveys included a number of common questions, designed to describe aspects of client case histories, to identify factors that might distinguish between persons who accept and those who reject the COP. These factors may be explored in a second report scheduled for December, 1983.

Finally, both surveys also assessed persons' satisfaction with aspects of the COP assessment.

Because both surveys included only fifty respondents each, some caution should be used in interpreting the fundings which are based on a relatively small number of cases.[1]

The first subsection, below, describes the reasons persons gave for turning down COP services. The second subsection describes clients' satisfaction with the community services provided to them and the third subsection describes client satisfaction with COP assessments.

WHY DO SOME CLIENTS TURN DOWN SERVICES?

Survey Methods

Based on a review of literature, early reports from COP counties, and discussions with persons familiar with the institutionalized elderly, a number of possible reasons for turning down COP services were identified. Possible reasons fell under the following general categories:

- someone else urged the client to enter a nursing home,
- the person felt s/he needed the medical services offered in the nursing home,
- the person felt s/he needed the non-medical services offered in the nursing home,
- the person entered the nursing home out of a need for companionship,

[1] Many assessment reports were not processed until November. Therefore it was not possible to begin the telephone surveys until mid-November. Since this report was due to the legislature January 1, it had to be completed in draft form by December 20, so there was very little time to conduct the two surveys, process, and analyze the data. Therefore it was decided to begin the analysis when 50 interviews for each survey were completed.

- the person wanted to be independent of family, friends or welfare, or
- the person was afraid of being a victim of crime if s/he did not enter the nursing home.

These six general categories were developed into sixteen questions included in a telephone survey of persons who reportedly turned down the COP and chose to enter a nursing home. (See appendix A for the "Client Refusal" telephone survey instrument.)

Because initial surveys suggested that very few of the clients who entered a nursing home could adequately respond to a telephone survey (in only two of the first 20 cases where a contact was attempted was the client able to answer the questions, in the opinion of the surveyor) it was decided that survey respondents would be persons identified on the PPOC as responsible relatives or guardians.

The survey began with all 127 persons who the county COP lead agencies indicated had been assessed, but reportedly refused a COP service plan and entered a nursing home because they or their guardian preferred nursing home care. Forty respondents could not be reached or were not called because the client had recently died, the client had left the nursing home, telephones were disconnected or had unlisted numbers, or the clients had not entered the nursing home identified by the COP agency. In addition, three clients contacted in nursing homes were found to be unable to answer questions, but guardians or relatives had left instructions not to be contacted. An additional 32 persons were not yet contacted at the time this analysis was begun. Tentative plans are to complete those 32 interviews in January. Therefore, interviews were completed with two

clients and 50 guardians or responsible relatives. To simplify presentation of the findings, only those surveys with guardians or responsible relatives are used in this analysis.

When the survey began, it was discovered that, according to the respondents, the client was often not the person who made the decision to enter the nursing home. Therefore, in addition to the questions contained on the survey instruments, each respondent was asked whether the client or someone else was primarily responsible for making the decision to reject the COP and enter a nursing home.

Findings

Decision-Maker

As indicated in table 48, twenty-eight of the fifty respondents (56 percent) reported that someone other than the person assessed had made the decision to reject the COP and enter the nursing home.

TABLE 48

Person Making Decision to Enter Nursing Home by County

County	Client	Someone Else	Unknown	Total
Pepin	5	1	0	6
Portage	2	2	1	5
Winnebago	2	7	0	9
Waupaca	2	1	0	3
Racine	10	15	0	25
Dane	0	2	0	2
Total	21	28	1	50

Only ten percent of the clients reported that the decision to enter a nursing home was not at least in part based on the fact that someone else urged them to do so. Eighty-six percent of the clients reported someone else urged them to enter the nursing home, two percent said their doctor said "no" but their family urged him/her to enter, and two percent didn't respond.

Number of Reasons Cited

The overwhelming majority of the cases cited multiple reasons for rejecting the COP and entering the nursing home. According to the respondents, most made the decision based on urging from their family and/or doctor, and they thought that they needed the services offered by a nursing home. Less frequently, the decision was based on the above reasons combined with the need for companionship.

What is more important, there were only 6 cases (12 percent of the total) in which only one reason was cited for entering a nursing home. In all six cases the single reason cited was that the clients' doctor wanted them to enter the nursing home. Of those six cases, four reported that someone other than the client made the decision to enter the nursing home, one reported the client made the decision and one respondent did not know who made the decision.

There were 7 additional cases (14 percent of the total) in which only 2 reasons were cited. The reasons were: 1) a family member wanted the person to enter a nursing home and 2) a doctor wanted the person to enter. In one additional case the respondent cited the two reasons above and also said the person thought s/he needed the services offered in the nursing home.

Of those eight cases in which only two or three reasons were cited, four reported that the client made the decision to enter and four said someone else made the decision.

Types of Reasons

As indicated in table 49, the most frequently cited reason for rejecting the COP services and entering a nursing home was that a doctor urged the client to enter. The second and third most frequently cited reasons were that a family member wanted the person to enter a nursing home and that the client felt he/she needed medical and non-medical services offered by the nursing home. The fourth most frequently cited reason was that the person felt life would be easier in a nursing home.

The sixth most frequently cited reason was that the client thought it was too difficult to do housework and the seventh most frequently cited reason was that the person wanted to be around other people. Table 49 presents the frequency with which other reasons were cited.

TABLE 49

Reasons for Entering a Nursing Home
(Reported by Responsible Relatives/Guardians)

Reason for Entering a Nursing Home	Total (N = 50)	
	%	Rank
Someone else urged them to enter:		
Family member wanted person to enter	76.0%	2
Doctor wanted person to enter	84.0	1
Friend wanted person to enter	2.0	15
Person felt s/he needed services offered in the nursing home	71.4	3
Person felt the need for non-medical services from a nursing home:		
Person felt life would be easier in nursing home	58.0	4
Person thought it was too difficult to prepare meals	52.0	5
Person felt s/he could not get around well	52.0	
Person thought it was too difficult to do housework	48.0	6
Person felt the need for companionship:		
Person wanted to be around other people	40.0	7
Person thought it would be less lonely	36.0	8
Person had friends or relatives in the nursing home and wanted to be with them	18.0	11
Other Reasons[a]	24.0	9
Person was afraid s/he could not get emergency medical help if s/he did not enter the nursing home	22.0	10
Person wanted independence:		
Person thought s/he would be a burden on others	14.0	12
Person wanted to be independent of family	12.0	13
Person did not want welfare services	10.0	14
Person was afraid of being a victim of crime	10.0	14

[a] Of the twelve respondents who cited "other" reasons, nine indicated that the client needed medical care or help with medications and it was thought that care could best be delivered in a nursing home. Most frequently mentioned was that the client may not take medications at the right time if he/she was not in the nursing home. Two respondents cited as "other reasons" that the clients liked the particular nursing home they choose to enter. And one respondent said that the client's doctor "didn't give her any choice" and said she should go to the nursing home.

ARE CLIENTS SATISFIED WITH THE SERVICES PROVIDED?

As noted above, a second telephone survey was conducted to determine whether persons for whom case plans were developed and who received COP services were satisfied with the services received. The client satisfaction survey asked a number of questions to determine if respondents were satisfied with aspects of the services as a whole. It also asked respondents to evaluate each individual service they received.

The client satisfaction survey began with a list of 85 of the 92 clients who had received COP-funded services by September 30. Two had died, seven had stopped receiving COP services and seven had disconnected or unpublished telephone numbers. Nineteen others had not been reached by the time this analysis was begun. Therefore, 50 interviews were completed and included in this analysis. This represents 54 percent of the population that had received COP-funded services by September 30th. In 54 percent of the cases, the respondent was someone other than the COP client.[1] Clients from La Crosse County were omitted from the survey because of the short time clients in those counties had been served. Rusk County did not report any COP-funded service clients so it also was omitted.

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[1] Respondents included COP clients, close relatives, or persons identified as responsible relatives or guardians.

Consideration of Nursing Home Care

The first survey question asked when nursing home care for the client was first seriously considered. In 30 percent of the cases the respondent (either the COP client or a responsible relative or guardian) said nursing home care was never seriously considered.

As an example, one client's son said a nursing home was never considered, but the client's doctor suggested the family talk to the county about services. In other cases, either the service recipient or a close relative (children, spouse or father) said they had never considered a nursing home placement and did not know of anyone who had considered it. A few clients were upset at the question and wanted to know who said they were considering entering a nursing home. (In such cases the telephone surveyor told the client that "there is probably a mistake in our records" and attempted to assure the clients that no one was considering placing them in a nursing home.)

In another 10 percent of the cases the respondent said they did not think nursing home placement had been seriously considered, but conceded that someone (either a doctor or a relative) may have considered it.

In contrast, none of the respondents in the survey of persons who turned down the COP said they were not seriously considering nursing home care.

This raises the possibility that 30-40 percent of those receiving COP services were not actually seeking or about to enter a nursing home.

There are other possible explanations for these results. Some respondents may have been reluctant to admit to the interviewer that they or someone in their family had been seriously considering a nursing home placement. It is also possible that, although the respondents were the COP clients themselves, close relatives, or the persons identified as the responsible relatives or guardians for the clients, that the respondent sometimes did not know that nursing home care had been seriously considered.

It should also be noted, as indicated in chapter XI, about 84 percent of the persons who received services had medical and social needs sufficient to be rated ICF-2 or higher, making them technically appropriate for nursing home care.[1] A review of the level of care of the 14 clients who were reported as definitely not considering nursing home admission showed that 82 percent were rated at ICF-2 or higher care levels and a review of the 5 respondents reported as probably not considering nursing home admission showed 2 of them to be rated at ICF-2 or higher care levels.[2]

General Satisfaction with Services

Questions 13 to 18 of the client satisfaction survey (see appendix A) were designed to measure various dimensions of satisfaction with the COP. For example, respondents were not only asked whether they were satisfied with the services they received overall, but whether they thought the client got the

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[1] There are two care levels (SNF and ICF-1) which are higher than the ICF-2 care level. Care levels below ICF-2 include ICF-3 and ICF-4.

[2] Care levels were reported for 11 of the 14 clients in the first group and for 3 of the 5 clients in the second group.

services he/she wanted, the services he/she needed, and whether, given the choices available, they would go back to the same agency for services again if they had similar needs.

As indicated in tables 50-55, respondents tended to be very satisfied with the program. In the overall satisfaction rating (table 54), 94 percent of the 50 respondents said they were generally satisfied with the services the client received. In 90 percent of the cases the respondent indicated the client got the services they wanted (table 50), and 96 percent said the services received generally met the client's needs (table 51). It may be worth noting that, as indicated in table 56, nearly all of the unfavorable responses came from respondents who were not themselves the service recipients.

TABLE 50

Whether Respondent Felt the Client Got the Types of Services S/he Wanted

	Types Wanted		
County	Yes	No	Total
Pepin	8	0	8
Portage	6	1	7
Winnebago	10	2	12
Waupaca	9	0	9
Racine	6	0	6
Dane	6	2	8
Total	45	5	50

TABLE 51

Whether Respondent Thought Services Generally Met Client's Needs

County	Met Needs		Total
	Yes	No	
Pepin	8	0	8
Portage	7	0	7
Winnebago	10	2	12
Waupaca	9	0	9
Racine	6	0	6
Dane	8	0	8
Total	48	2	50

TABLE 52

Whether Respondent Would Recommend COP to a Friend With Similar Needs

County	Would Recommend			Total
	Yes	No	Don't Know	
Pepin	8	0	0	8
Portage	6	0	1	7
Winnebago	9	2	1	12
Waupaca	9	0	0	9
Racine	6	0	0	6
Dane	8	0	0	8
TOTAL	46	2	2	50

TABLE 53

Whether Respondent Thought COP Services Helped the Client With His/Her Problems

County	Helped		Total
	Yes	No	
Pepin	8	0	8
Portage	7	0	7
Winnebago	10	2	12
Waupaca	8	1	9
Racine	6	0	6
Dane	8	0	8
Total	47	3	50

TABLE 54

Whether Respondent Was Generally Satisfied With the Services Overall

County	Satisfied Overall		Total
	Yes	No	
Pepin	8	0	8
Portage	6	1	7
Winnebago	10	2	12
Waupaca	9	0	9
Racine	6	0	6
Dane	8	0	8
Total	47	3	50

TABLE 55

Whether Respondent Thought They Would Go Back to the Same Agency if They Needed Help Again

County	Would Go Back		Total
	Yes	No	
Pepin	8	0	8
Portage	7	0	7
Winnebago	10	2	12
Waupaca	9	0	9
Racine	6	0	6
Dane	8	0	8
Total	48	2	50

TABLE 56

Negative Responses by Type of Respondent

Type of Negative Response	Type of Respondent		Total
	Client (N=23)	Someone Else (N=27)	
Not Types of Services Wanted	1	4	5
Services Did Not Meet Needs	0	2	2
Would Not Recommend	0	2	2
Services Did Not Help	0	3	3
Not Satisfied Overall	0	3	3
Would Not Go Back	0	2	2

Satisfaction with Individual Services

Respondents were read a list and brief description of each service the client received, according to the case plan reports submitted by the county. For those services that the respondent recalled that the client actually received, the surveyor asked whether they were satisfied with the quality and amount of the service.

In about eight percent of the cases the respondent said the client definitely did not receive a service listed on the case plan.

The most frequently reported services received were supportive home care, case management, home health services, home delivered meals and transportation.

As indicated in Table 57, 40 respondents recalled receiving supportive home care. Ninety percent said they were satisfied with the quality of those services. Eighty-eight percent thought the client received the right amount of supportive home care, while twelve percent thought the client had not received enough of the service.

Referring to Table 58, 40 respondents recalled receiving case management services. Ninety-two percent said they were satisfied with the quality of those services. Ninety-five percent thought the client received the right amount of case management services while five percent thought the client had not received enough of the service.

As indicated in Table 59, 24 respondents recalled receiving home health services. All 24 said they were satisfied with the quality of those services. Ninety-two percent thought the client received the right amount of home health services while eight percent thought the client had not received enough of the service.

TABLE 57

Satisfaction with Supportive Home Care[a]

County	Quality		Amount of Service Provided		
	Good	Bad	Right Amount	Too Much	Not Enough
Pepin	4	1	4	0	1
Portage	6	0	5	0	1
Winnebago	5	3	5	0	3
Waupaca	8	0	8	0	0
Racine	5	0	5	0	0
Dane	8	0	8	0	0
Total	36	4	35	0	5

[a] N = 40 respondents who recalled receiving supportive home care.

TABLE 58

Satisfaction with Case Management Services[a]

County	Quality		Amount of Service Provided		
	Good	Bad	Right Amount	Too Much	Not Enough
Pepin	4	0	4	0	0
Portage	6	0	6	0	0
Winnebago	9	2	9	0	2
Waupaca	7	0	7	0	0
Racine	4	0	4	0	0
Dane	7	1	8	0	0
Total	37	3	38	0	2

[a] N = 40 respondents who recalled receiving case management services.

TABLE 59

Satisfaction with Home Health Services[a]

County	Quality		Amount of Service Provided		
	Good	Bad	Right Amount	Too Much	Not Enough
Pepin	3	0	3	0	0
Portage	1	0	1	0	0
Winnebago	8	0	7	0	1
Waupaca	7	0	6	0	1
Racine	5	0	5	0	0
Dane	0	0	0	0	0
Total	24	0	22	0	2

[a] N = 24 respondents who recalled receiving home health services.

TABLE 60

Satisfaction with Home Delivered Meals[a]

County	Quality		Amount of Service Provided		
	Good	Bad	Right Amount	Too Much	Not Enough
Pepin	2	0	2	0	0
Portage	0	0	0	0	0
Winnebago	2	0	2	0	0
Waupaca	1	0	1	0	0
Racine	0	1	1	0	0
Dane	0	0	0	0	0
Total	5	1	6	0	0

[a] N = 6 respondents who recalled receiving home delivered meals.

Referring to table 60, only six respondents recalled receiving home delivered meals. Eighty-three percent were satisfied with the quality of the home delivered meals and all six thought the client got the right amount of the service.

As indicated in table 61, five respondents recalled receiving transportation services. All respondents were satisfied with the quality of the service and all felt the client received the right amount.

TABLE 61

Satisfaction with Transportation Services[a]

County	Quality		Amount of Services Provided		
	Good	Bad	Right Amount	Too Much	Not Enough
Pepin	2	0	2	0	0
Portage	1	0	1	0	0
Winnebago	1	0	1	0	0
Waupaca	1	0	1	0	0
Racine	0	0	0	0	0
Dane	0	0	0	0	0
Total	5	0	5	0	0

[a] N = 5 respondents who recalled receiving transportation services.

ARE CLIENTS SATISFIED WITH COP ASSESSMENTS?

Respondents for clients who turned down COP services and respondents for clients who received COP services were asked to evaluate aspects of the COP assessment the client received.[1] Only 27 (54 percent) of the respondents in cases where the client refused COP services could recall an assessment. Forty-one (82 percent) of the respondents in cases where the client received COP services recalled the assessment. Those who recalled the assessment were asked: 1) whether the right kinds of questions were asked during the assessment, 2) whether there were too many questions and 3) whether the questions were too personal.

Referring to table 62, for the 27 respondents who recalled the assessment in cases where the client reportedly refused the COP services, only 2 thought that too many questions were asked and 2 thought questions were too personal. The remainder thought the assessment asked the right kinds of questions, about the right amount of questions and did not think the questions asked during the assessment were too personal.

[1] Findings in this section are based on surveying 50 of the 127 clients who turned down COP services and 50 additional clients from the group of 92 other clients who received COP-funded services.

Table 63 shows responses of the 41 respondents who recalled the assessment in cases where the client received COP services. In two cases the respondent thought the county assessment did not ask the right kinds of questions. In one case the respondent thought too many questions were asked and in six cases the respondent thought the questions were too personal. In a small number of cases the respondent replied "don't know." But in nearly all of the remaining 41 cases the respondent thought that the assessment asked the right kinds of questions, about the right number of questions and that the questions asked during the assessment were not too personal.

TABLE 62

Evaluation of COP Assessment in Cases Where the Client Refused COP Services[a]

County	Assessment Asked Right Questions			Too Many Questions Asked			Questions too Personal		
	Yes	No	Don't Know	Yes	No	Don't Know	Yes	No	Don't Know
Pepin	1	0	3	0	0	3	0	0	3
Portage	2	0	0	0	2	0	0	2	0
Winnebago	5	0	3	0	5	3	0	5	3
Waupaca	2	0	0	0	2	0	0	2	0
Racine	8	0	1	1	6	2	1	6	2
Dane	2	0	0	1	1	0	1	1	0
Total	19	0	7	2	16	8	2	16	8

[a] N = 27 respondents who recalled the assessment.

TABLE 63

Evaluation of COP Assessment in Cases Where the Client Received COP Services[a]

County	Assessment Asked Right Questions			Too Many Questions Asked			Questions too Personal		
	Yes	No	Don't Know	Yes	No	Don't Know	Yes	No	Don't Know
Pepin	6	0	1	1	6	0	1	6	0
Portage	5	0	1	0	5	1	1	4	1
Winnebago	5	1	1	0	6	1	0	6	1
Waupaca	8	1	0	0	8	1	2	6	1
Racine	3	0	1	0	3	1	0	3	1
Dane	7	0	0	0	7	0	2	5	0
Total	34	2	4	1	35	4	6	30	4

[a] N = 41 respondents who recalled the assessment.

Results indicate a general satisfaction with the assessment process. The largest area of complaint seems to be that the questions are "too personal." However, a relatively small number of respondents (8 out of the 67 who recalled the assessment process) thought the questions were too personal. And, one should note that it is necessary to gather some "personal" information to determine if a client is in need of services and whether s/he meets criteria for financial assistance for the services. In interpreting these results one should also recall that most counties used different assessment processes and instruments.

XIV. SUMMARY

This evaluation of the initial operation of county Community Options Programs was based on information obtained from COP county reports, patient records from the Division of Health's Bureau of Quality Compliance, on-site interviews of COP county staff and community representatives, the Department's Medicaid Management Information System, and telephone surveys of clients who were assessed by the program. Part I of the report focused on the policies and procedures developed to operate the program in each of the counties and on county staff and community representatives' opinions regarding the operation of the program. Part II of the report evaluated COP county efforts to target services to the type of clients described in the legislation and guidelines for the program; described the type, amount, and cost of services provided to clients in the initial months of program operation; and presented findings from two client telephone surveys. (One of these surveys was conducted to determine why some of the clients assessed, or their guardians, preferred nursing home care to community services. The second survey was conducted to assess COP client satisfaction with community services. Both surveys also assessed client satisfaction with COP assessments.)

Because the findings in this report are based on only a few months of program operation they should be considered preliminary findings. The patterns observed might easily differ from those which will emerge after the COP is more fully implemented. Following is a summary of the findings from part II of the evaluation. (A summary of the findings from part I appears in chapter X.)

Program Operation

By county, the months of actual program operation were: 2 months (La Crosse County), 4.5 months (Dane County), 5.5 months (Winnebago County), 6 months (Portage and Racine counties), 6.5 months (Pepin County), 7 months (Rusk County), and 8 months (Waupaca County).

Referrals

- COP counties reported they received 592 referrals by September 30th. The number of referrals per month of actual program operation per county ranged from 3 to 28.6.

- Most of those referred were elderly persons without categorical disabilities such as chronic mental illness or drug abuse.

- Slightly over half (51 percent) of the persons referred were in a hospital when referred, approximately 40 percent were in community settings, and the remaining 9 percent were in a nursing home or DD center.

- Sixty-five percent of the persons referred were assessed. The most frequent reasons for not assessing clients were that they waived the assessment or were not in the target group.

Assessments

- The average age of the 384 persons assessed, reported for 71 percent of those assessed, was 76 years.

- The level of care of clients assessed, reported for 65 percent of the cases, was SNF (45 percent), ICF-1 (29 percent), ICF-2 (14 percent), ICF-3 (10 percent), and ICF-4 (1 percent). Only 2 of the 249 clients for whom data were obtained were below an ICF-4 level.

- The proportion of clients at each of the five care levels varied by county.

- Forty-eight percent of the one hundred clients assessed through May were found to be eligible for Medicaid at the time they were assessed or retroactively certified to that date within six months.

- Case plans were not developed for 58 percent of the 384 persons who were assessed. Eighty-six percent of these persons were estimated to be at an SNF or ICF-1 level of care.

- The most frequently reported reason for not developing a case plan for a client assessed was that the person preferred nursing home care. This was reported for 50 percent of the cases. For another 12 percent of the cases, the reason for not developing a case plan was the person's guardian or family preferred nursing home care (8 percent and 4 percent of the cases respectively).

- A telephone survey to clients or guardians who preferred nursing home care showed clients had a number of reasons for entering a nursing home. Ninety-eight percent of the respondents cited more than one reason. Most frequent reasons were that the doctor wanted the person to enter (84 percent), a family member wanted the person to enter (76 percent), and the person felt s/he needed the services offered in a nursing home (71 percent).

- The influence of other persons was found to be very strong. In 57 percent of the 49 cases responding, it was indicated that someone other than the client made the decision to enter a nursing home and only 10 percent of the respondents reported that the decision to enter the nursing home was not partially the result of the urging of other persons.

- Only 54 percent of the respondents for clients who had refused COP services and 82 percent of those who had received COP services who were surveyed recalled the assessment process. Of those who <u>did</u> recall the assessment process, 85 percent of the respondents for clients who refused service and 78 percent of the respondents for those who received services, thought the assessment asked the right kinds and number of questions and did not think the questions were too personal.

<u>Case Plans</u>

- Case plans were developed for 163 persons.

- Over 60 percent of the persons for whom case plans were developed were rated as needing skilled (SNF) or ICF-1 intermediate care.

- Case plans included an average of 3.3 separate services including case management.

- The average number of services in case plans ranged from two to six per county.

- Supportive home care and case management were the services most frequently identified in case plans.

- All but 11 of the case plans developed were implemented or scheduled to be implemented.

- In the few cases when case plans were not implemented, the reason was usually that the person preferred nursing home care or had to be hospitalized.

Services

- Services were provided to 140 clients by September 30th. Ninety-two of these persons received COP-funded services.

- Only six of the clients who received community services were in a nursing home at the time they were assessed.

- The average age of the clients served was 74.2 years.

- Sixty-one percent of the clients served were female and 50 percent were widowed.

- Sixty-two percent of the 140 persons who received community services were estimated to need SNF or ICF-1 level of care. However, a third of the 50 clients receiving COP services who were surveyed by phone reported that nursing home care was never seriously considered and another 10 percent said they did not think nursing home placement had never been seriously considered, but noted that someone else (doctor or relative) may have considered it.

- Sixty-eight percent of the clients receiving community services were reported to be elderly clients without categorical disabilities such as chronic drug abuse.

- By September 30th, 69 of the 140 clients receiving community services were terminated from the COP caseload. Twenty-three of these were clients who had received COP-funded services.[1] Seventy percent of these 23 clients were terminated because they had entered a nursing home or died.

- By September 30th, persons receiving COP-funded services had received an average of 65.9 days of service per client.

- On average, clients receiving COP-funded services received four different services (including services from other sources and case management services).

- The most common use of COP service funds was to provide supportive home care. This accounted for 66 percent of the COP funds used.

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[1] The other 46 clients who were terminated from the COP caseload may have continued to receive community services from other (non-COP) funding sources.

- In addition to COP-funded services, clients also received services from other public funding sources and from natural supports.

- Over 90 percent of the 50 clients receiving COP services who were surveyed reported they were generally satisfied with the services provided; 90 percent said they got the services they wanted; and 96 percent reported services generally met client's needs.

- Clients generally recalled receiving the type of services originally listed in their case plans suggesting few major changes in the type of services identified in case plans. (The amount or frequency may, however, have changed).

Cost of Services

- Counties reported spending $56,043 of COP service funds by September 30th.

- It was estimated that COP service dollars averaged $11.51 per client per day of service which would be $349.90 per month.

- Preliminary reports on 46 cases of clients receiving COP service funds suggested COP funded 58 percent of the total costs of community services for these clients; this, however, was judged an over-estimate because Medicaid and Medicare expenditures were underreported. Data gathering and analysis of total costs, including Medicare and Medicaid, will be a major focus of the next COP evaluation scheduled for December of 1983.

PART III. CONCLUSIONS AND RECOMMENDATIONS

The following conclusions and recommendations are based on the findings in parts I and II of this report. (Summaries of findings are presented in chapters X and XIV of the report.)

IMPLEMENTATION

- The number of referrals obtained in the first months of program operation and the percent of the referrals that were not assessed (35 percent) imply that counties will probably assess fewer than 1,000 clients by the end of 1982. In comparison, the amount of money allocated for assessment for the calendar year was enough to assess 3,534 clients -- a number comparable to 84 percent of the number of persons admitted to nursing homes in the eight COP counties in 1981. Unless the current rate of referral and assessment increases, therefore, it will take longer than originally expected to implement the program to the extent where all potential nursing home admissions, as well as current nursing home residents wishing to be assessed, are assessed.

- By September 30th, counties reported spending $56,043 of the monies allocated to provide community services to clients who were eligible for Medicaid at the time they were assessed or expected to become eligible within six months. The money spent represented approximately 20 percent of

the allocation adjusted for the months of actual program operation in each of the eight counties. Policies for advancing funds to COP counties for 1983 need to be re-examined in light of the use of funds in the first nine months of 1982. This is also suggested because the counties which volunteered to operate programs in 1982 may have had a higher level of commitment to the program and a greater ability to implement the program than some of the counties which will start operating programs in 1983-85. (One of the criteria for selecting pilot counties was their potential for implementing the program quickly.)

- A higher proportion of the clients assessed by the program received community services than originally expected. (Thirty-six percent versus ten percent respectively.) This finding needs to be considered in relationship to other findings regarding the type of clients that were assessed. Thus, only slightly over half of the clients referred were hospitalized whereas over 70 percent of nursing home admissions typically are from the hospitals. Only 74 percent of the clients assessed were at an SNF or ICF-1 level of care whereas 93 percent of the admissions to nursing homes in the eight COP counties in 1981 were at these levels; and a third of the clients who received community services said they were not actually intending to enter a nursing home at the time they were assessed.

Thus the proportion of clients assessed who received community services in the initial months of program operation probably overestimates the percent that will be found when counties expand their program to assess more hospitalized clients, other clients with more intensive medical and social

needs, and current residents of nursing homes who wish to be assessed. If the target group is expanded to include ICF-3 clients, as proposed, however, the ratio may remain similar to that observed initially.

- o County phase-in plans were in some cases quite complex and overall did not correspond very closely to the proportions of referrals obtained from various locations. It may, therefore, not be necessary to require counties to specify detailed schedules for phasing-in referrals from various locations in the future.

- o Counties reported a number of factors which delayed the implementation of their programs. These factors ranged from local barriers such as difficulties in finalizing interagency agreements to problems with the state guidelines and policies for program operation. It was also found that the county that provided the most days of service to clients by September 30th was the only county that adapted an assessment process previously used in the county. It is recommended, therefore, that the type of problems counties reported be reviewed and that efforts be made to revise the program requirements accordingly as appropriate or provide additional technical assistance to counties. These efforts are recommended to facilitate faster implementation in the future.

TARGETING

- Clients with more extensive medical needs (SNF-ICF-1), while representing 74 percent of those assessed, represented 62 percent of those served. It was also found that 86 percent of those assessed for whom case plans were not developed were at the SNF or ICF-1 care levels. This suggests that consideration be given to testing the use of a short form assessment process so that clients who are very unlikely to be served will not have to go through the complete assessment process.

  This finding also suggests that the $400 per month guideline for COP service dollars could be adjusted to reflect the proportions of clients served at each of the levels of care.

- Only 48 percent of the 100 clients assessed through May were found to be eligible for Medicaid reimbursement of the assessments. This suggests that either 1) the initial ratio of GPR to Medicaid assessment dollars (which projects that 67 percent of the clients assessed would be eligible for Medicaid reimbursement of the assessment costs) be adjusted, or 2) that counties be encouraged to develop more referrals of clients eligible for Medicaid.

- Of the persons served, 84 percent were evaluated as having social and medical needs appropriate for Medicaid to reimburse nursing home care (SNF-ICF-2). Another four percent may also have been eligible because they

were developmentally disabled.[1] In contrast, a third of the clients served who were surveyed said they were not actually intending to enter a nursing home. This suggests that in addition to assessing client's medical and social needs, counties should be required to verify clients' intentions to enter a nursing home before they provide COP-funded community services to clients. It should be noted that in 1983 when requirements for obtaining standard data on clients' social and medical needs are dropped, it will be very difficult, if not impossible, to determine how many of the clients served/assessed are in the target group for the COP.

- The program initially did not obtain large proportions of referrals of clients who were categorically disabled. This was most likely a result of county phase-in plans. The proportion, however, was comparable to the proportions of disabled persons in the population of nursing home residents. The proportion of disabled clients served was also slightly greater than the proportion of disabled clients in the group of clients initially referred suggesting that counties did not screen-out disabled clients.

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[1] Another four percent may also have been eligible because they were nursing home residents prior to October 1, 1981 and thus were not affected by the policy excluding Medicaid reimbursement for ICF 3-4 geriatric patients.

- All but seven percent of the clients for whom case plans were developed received services by September 30th or were expected to receive services. Counties therefore were effective in targeting case plan monies to persons who would actually receive community services.

SERVICE COSTS

- On average, the amount of COP service funds used was $11.51 per day of service. This would represent $349.90 a month. This was under the $400.00 monthly guideline, possibly because greater proportions of clients at the lower care levels were served than was expected when the $400 figure was established.

- Preliminary data on 46 of the 92 COP-funded service clients suggested that COP service funds represented 58 percent of the funds needed to maintain clients in community settings. This was judged to over-estimate the COP share because Medicare and Medicaid data were under-reported. Further study is planned to determine the total costs of community services.

- By September 30th, 25 percent of the 92 COP-funded service clients had been terminated from county COP caseloads. (The most frequent reasons for terminating COP funded service clients were because the client died or entered a nursing home.) Further study is needed to assess the cost savings relative to the length of the service period. Assessment and case plan development costs should be included in this analysis.

TYPE OF SERVICE

- Clients receiving COP-funded services received an average of four separate services including case management. This suggests that the need for extensive case management services may be less than originally expected.

- The high percentage of COP dollars being used to fund supportive home care services (65 percent) suggests that guidelines are needed to address the interrelationship of COP funded, Title III Aging funded, and Title 20 funded supportive home care.

- Clients were generally satisfied both with the assessment process and with the type, amount, and quality of services provided to them. This implies counties were effective in implementing these aspects of program operation.

- Counties did not usually develop new services with COP funds and cited the lack of "up front" funding to do so. Because counties did not report much difficulty in obtaining adequate services/living arrangements for clients there does not appear to be any immediate need to provide "up front" funding to develop new services for COP clients. If, however, the program begins to serve a more impaired client group, or a greater number of clients (thus draining existing resources) it may be necessary to re-consider this issue.

RELATIONSHIPS WITH PHYSICIANS

- Only three of the eight counties reported that they had "good" communication with physicians during the initial months of program operation. Problems noted were that physicians were not referring clients to the program, tended to prefer nursing homes to community services, were generally unaware of the program, and needed to develop more trust in social workers.

- The survey of clients who did not obtain a case plan because they or their guardian preferred nursing home care highlighted the importance of the physician's role in making decisions concerning the type of long term care to be provided to clients. Eighty-four percent of the respondents said that the decision to enter a nursing home was affected by the fact that a physician wanted the client to enter a nursing home.

These findings suggest that additional efforts are needed (at both state and local levels) to provide physicians with information about the Community Options Program and to work with them in developing long term support services for the clients assessed by the program.

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WISCONSIN DHSS
Division of Community Services
DCS-814 (Revised 10-82)

APPENDIX A

County Reporting Forms
COP ASSESSMENT STATUS AND RESULT INFORMATION
ITEM TWO - Page 1

Date Form Completed

County

IDENTIFYING INFORMATION

1. SERVICE NUMBERS (If Known) - Medicare	Medicaid	TIS/SSIS

2. REFERRAL DATE	3. COUNTY OF RESIDENCE	4. Name of NURSING HOME Being Sought (If Known)

5. PAY STATUS

- a. ☐ MA Eligible
- b. ☐ Potentially MA Eligible
  - ( ) Within 6 Months
  - ( ) Within 1 Year
- c. ☐ Private Pay

6. AGE OR DISABILITY (check all that apply)

- a. ☐ Elderly
- b. ☐ Child
- c. ☐ Chronic Drug Abuse
- d. ☐ Developmentally Disabled
- e. ☐ Chronically Mentally Ill
- f. ☐ Physically Disabled
- g. ☐ Other (specify) _____

7. REFERRAL SOURCE AND RESIDENCE

	Residence At Time of Referral (Name, if applicable)	Check Referring Agency	Usual Residence (If Different Than Column 1)
a. Nursing Home		☐	
b. D. D. Center		☐	
c. Hospital (Non-Psychiatric)		☐	
d. Psychiatric Hospital		☐	
e. CBRF or Group Home		☐	
f. Adult Family Home		☐	
g. Own Home		☐	
h. Other _____		☐	

8. INTAKE ACTIONS

- a. ☐ Person was Assessed (Go to # 9)
- b. ☐ Person was NOT Assessed; because they ►
  1. ( ) Did not meet the COP target group definition
  2. ( ) Were not covered in the county phase-in plan
  3. ( ) Declined assessment
  4. ( ) Could not be assessed before placement action had to be taken
  5. ( ) Other (describe) _____

STOP if the person was not assessed

ASSESSMENT INFORMATION

9. PERSON'S NAME	10. ASSESSMENT DATES - Began	Completed

11. PERSONS DOING THE ASSESSMENT - Name	Title	Agency

12. PRELIMINARY ASSESSMENT OUTCOME

- a. ☐ Case Plan Being Developed
- b. ☐ Case Plan NOT Being Developed-check all that apply
  1. ( ) Insufficient funds to develop case plan
  2. ( ) Insufficient funds to provide the community alternatives
  3. ( ) Insufficient program or program openings
  4. ( ) Person preferred nursing home care
  5. ( ) Guardian (if any) preferred nursing home care
  6. ( ) Other (specify) _____
- c. If NO case plan, and if known, what happened to person? (e.g. name & location of facility entered if applicable)
  ► _____

13. PATIENT PLAN OF CARE FORM (PPOC) (check one)

- a. ☐ PPOC currently on file in DHSS
- b. ☐ Complete PPOC sent to DHSS as part of nursing home placement
- c. ☐ Partial PPOC completed with physician review
  Physician's Name ► _____
- d. ☐ Partial PPOC completed without physician review
  Attending Physician's Name and Telephone Number:
  ► _____
  ► _____

230

(Completion of this form is in compliance with the guidelines established under 46.27, Wis. Stats.)

WISCONSIN DHSS
Division of Community Services
DCS-814 A (Revised 10-82)

COP ASSESSMENT STATUS AND RESULT INFORMATION
ITEM TWO - Page 2

(Completion of this form is in compliance with the guidelines established under S. 46.27, Wis. Stats.)

(Attach additional sheets, if necessary)

14. PERSON'S PREFERENCES - Describe the person's expressed preferences for service arrangements and for living arrangements.

15. COMMUNITY OPTIONS - Describe as fully as possible the services and other support arrangements (e.g. family involvement) which would enable the person to live in a non-institutional community environment with as much dignity as possible. Include, to the extent possible: (a) rough dollar estimates (or units) for each service; and (b) the community living arrangement type.

NOTE: That more than one arrangement (options) may be described and the current availability (or non-availability) of resources for the alternative(s) should not be a factor in making the description.

WISCONSIN DHSS
Division of Community Services
DCS-815 (Revised 10-82)

COP CASE PLAN REPORT

(Completion of this form is in compliance with the guidelines established established under S. 46.27, Wis. Stats.)

(Complete for each person receiving COP case plan.)

PERSON'S NAME			COUNTY	DATE FORM COMPLETED
Medicaid No.	Medicare No.	SSIS/TIS No.	Date Services Began or Will Begin:	Date Plan Was Completed:
PERSONS DEVELOPING OR ARRANGING THE PLAN - Name(s) and Agency(ies)				

1. LIVING ARRANGEMENT (Indicate arrangement agreed upon)

- ☐ a. Own Home
- ☐ b. Apartment - Number of other non-staff residents (client's unit only) ▶ _____
- ☐ c. Congregate Living - Number of other non-staff residents (client's unit only) ▶ _____
- ☐ d. CBRF - Number of other non-staff residents (total number) ▶ _____
- ☐ e. Adult Family Home - Number of other non-staff residents (total number) ▶ _____
- ☐ f. Other (describe) ▶ _____

2. NATURAL SUPPORTS

a. Indicate natural supports which: (1) exist; and (2) potentially can and will provide assistance.

	Exist	Can and Will Assist	Comments
Spouse	☐	☐	
Adult Child(ren)	☐	☐	
Parent(s)	☐	☐	
Close Friends	☐	☐	
Extended Family	☐	☐	
Other (describe)	☐	☐	

b. Describe the assistance to be provided by natural support systems ▶ _____

3. FUNDING AND SOURCES SUMMARY (Indicate the average monthly expenditures by major funding source for this individual.)

Major Source	Before COP	Expected Under COP
a. COP	$	$
b. MTA (include T. XX, T. IV, capacity building, county match, etc.)	$	$
c. Title III (Older Americans Act)	$	$
d. Private Payments (pensions, SSI, Social Security, assets, uniform fees)	$	$
e. Medicaid (If dollar estimate is impractical, simply check)	$	$
f. Medicare (If dollar estimate is impractical, simply check)	$	$
g. Div. Voc. Rehab. (If dollar estimate is impractical, name service[s])	$	$
h. HUD Section 8 (If dollar estimate is impractical, simply check)	$	$
i. Other (describe) _____	$	$

4. INCOME SUMMARY (Identify by major source the average monthly income available to the individual.)

a. SSI	$	e. Social Security	$
b. SSDI	$	f. Pensions	$
c. Food Stamps	$	g. Assets (monthly)	$
d. Salaries, Wages, etc.	$	h. Other _____	$

5. CASE PLAN IMPLEMENTATION - If this case plan was not implemented and the person DID NOT remain as a COP client, check why.

- ☐ a. Insufficient funds to develop community alternatives
- ☐ b. Insufficient program or program openings
- ☐ c. Person preferred nursing home care
- ☐ d. Guardian (if any) preferred nursing home care
- ☐ e. Other (specify) ▶ _____

Name facility or residence entered ▶ _____

	AVE. MONTHLY SERVICE DOLLARS EXPECTED FROM MAJOR FUNDING SOURCES			AVE. MONTHLY UNITS EXPECTED	
	COP FUNDS (Total)	FUNDS FROM OTHER SOURCES (Total)	TOTAL FUNDS	(Label Unit Type)	
I. Social and Economic Support					
1.1 Child Day Care	$	$	$		hours
1.2 Adult Day Care					hours
1.3 Respite Care					hours
1.4 Supportive Home Care					hours
1.5 Housing Assistance					hours
1.6 Home Modification/ Energy Assistance					hours
1.7 Specialized Transportation and Escort					hours
1.8 Community Support					hours
1.9 Work-Related Services					hours
II. Alternate Living					
2.2 Adult Family Home	$	$	$		days
2.3 Foster Home (children)					days
2.4 Group Home (Note: for CBRF see 5.6)					days
2.5 Shelter Care					days
IV. Well-Being					
4.1 Congregate Meals/ Nutrition Education	$	$	$		meals
4.2 Home Delivered Meals					meals
4.3 Recreation/Alternative Activities					hours
4.5 Preventative Education/ Adjustment Skill Bldg.					hours
4.6 Protective Placement					hours
4.7 Guardianship					hours
V. Maintaining/Improving Personal, Physical and Mental Health					
5.1 Crisis Intervention	$	$	$		hours
5.2 Detoxification					days
5.3 Inpatient (CANNOT be COP funded)					days
5.4 Child Care Institution (CANNOT be COP funded)					days
5.5 D.D. Center (CANNOT be COP funded)					days

	AVE. MONTHLY SERVICE DOLLARS EXPECTED FROM MAJOR FUNDING SOURCES			AVE. MONTHLY UNITS EXPECTED	
	COP FUNDS (Total)	FUNDS FROM OTHER SOURCES (Total)	TOTAL FUNDS	(Label Unit Type)	
V. (Continued)					
5.6 Community Based Treatment Facility	$	$	$		days
5.7 Counseling/Therapeutic Resources					days
5.8 Day Svcs/Treatment					days
VI. System Access					
6.2 Information & Referral	$	$	$		contacts/ hours
6.4 Case Management/ Service Coordination					hours
6.5 Legal & Defense Resources					hours
6.8 Placement Assistance & Monitoring					hours
VII. Management					
7.1 Manpower Training & Development	$	$	$		
7.2 Agency/Systems Management					
VIII. Health Services: Medicare, Medicaid - NOT Included in Section V (Average monthly units expected, if dollar estimate is impractical)					
1. Home Health Aide/ Private Nursing					visits
2. Therapy (PT, OT, Speech, etc)					
3. Drugs					
4. Physician					
5. Dental Care					
6. Hospitalization					days
7. Nursing Home Utilization					days
8. Other Typically Major Medicaid Services (Name)					
IX. Other (specify)					

COP CASE PLAN SERVICE DETAIL

Division of Community Services DCS-815A (Rev. 10-82)

(Completion of this form is in compliance with the guidelines established under S. 46.27, Wis. Stats.)

WISCONSIN DHSS
Division of Community Services
DCS-816 (Issued 2-82)

COP SERVICE REPORT
YEAR-TO-DATE SUMMARY

▶ Complete for each person receiving COP-funded services

PERSON'S NAME			COUNTY	DATE FORM COMPLETED
Medicaid No.	Medicare No.	SSIS/TIS No.	DATE SERVICES BEGAN ▶	TIME PERIOD: ☐ YTD thru 9-82 ☐ YTD for CY 1982

1. CURRENT CLIENT STATUS

☐ a. Currently a COP Client (go to #2)
☐ b. Terminated - Termination Date ▶ _____
c. Reason for Termination
▶ _____
d. Living Arrangements after Termination (Name of residence, if not own home)
▶ _____
e. Other Comments and Description of What Happened to the Individual after Termination
▶ _____

NOTE: IF TERMINATED, GO TO QUESTION 3.

☐ f. On Hold (describe circumstances)
▶ _____

2. CURRENT LIVING ARRANGEMENT (Indicate the living arrangement at the time of this report.)

☐ a. Own Home
☐ b. Apartment - Number of other non-staff residents (client's unit only) ▶ _____
☐ c. Congregate Living - Number of other non-staff residents (client's unit only) ▶ _____
☐ d. CBRF - Number of other non-staff residents (total number) ▶ _____
☐ e. Adult Family Home - Number of other non-staff residents (total number) ▶ _____
☐ f. Other (describe) _____

3. NATURAL SUPPORTS

a. Indicate the natural supports which provide assistance and describe assistance provided.

☐ Spouse _____
☐ Adult Child(ren) _____
☐ Parent(s) _____
☐ Close Friends _____
☐ Extended Family _____
☐ Other _____

4. FUNDING SOURCES SUMMARY (Indicate the total expenditures by major funding source for the individual during the time period covered by this report.)

a. COP . . . . . $_____
b. MTA (Including T. XX, T. IV, capacity building, county match, etc.). . . . . $_____
c. Title III (Older Americans Act) . . . . . $_____
d. Private Payments (e.g. from pensions, SSI, Social Security, assets, uniform fees, etc.). . . . . $_____
e. Medicaid (If dollar estimate is impractical, simply check) . . . . . $_____
f. Medicare (If dollar estimate is impractical, simply check) . . . . . $_____
g. Division of Vocational Rehabilitation (If dollar estimate is impractical, name the service[s]) . . . $_____
h. HUD Section 8 (If dollar estimate is impractical, check if rent is subsidized) . . . . . $_____
i. Other (describe) _____ . . . . . $_____

5. INCOME SUMMARY (Identify by major source the average monthly income now available to the individual.)

a. SSI $_____
b. SSDI $_____
c. Food Stamps $_____
d. Salaries, Wages, etc. $_____
e. Social Security $_____
f. Pensions $_____
g. Assets (monthly) $_____
h. Other _____ $_____

Check One:
☐ YTD thru 9-82
☐ YTD for CY1982

	TOTAL SERVICE DOLLARS EXPENDED YEAR-TO-DATE FROM MAJOR FUNDING SOURCES			TOTAL YEAR-TO-DATE UNITS DELIVERED	
	COP FUNDS (Total)	FUNDS FROM OTHER SOURCES (Total)	TOTAL FUNDS	(Label Unit Type)	
I. Social and Economic Support					
1.1 Child Day Care	$	$	$		hours
1.2 Adult Day Care					hours
1.3 Respite Care					hours
1.4 Supportive Home Care					hours
1.5 Housing Assistance					hours
1.6 Home Modification/ Energy Assistance					hours
1.7 Specialized Transportation and Escort					hours
1.8 Community Support					hours
1.9 Work-Related Services					hours
II. Alternate Living					
2.2 Adult Family Home	$	$	$		days
2.3 Foster Home (children)					days
2.4 Group Home (Note: for CBRF see 5.6)					days
2.5 Shelter Care					days
IV. Well-Being					
4.1 Congregate Meals/ Nutrition Education	$	$	$		meals
4.2 Home Delivered Meals					meals
4.3 Recreation/Alternative Activities					hours
4.5 Preventative Education/ Adjustment Skill Bldg.					hours
4.6 Protective Placement					hours
4.7 Guardianship					hours
V. Maintaining/Improving Personal, Physical and Mental Health					
5.1 Crisis Intervention	$	$	$		hours
5.2 Detoxification					days
5.3 Inpatient (CANNOT be COP funded)					days
5.4 Child Care Institution (CANNOT be COP funded)					days
5.5 D.D. Center (CANNOT be COP funded)					days

	TOTAL SERVICE DOLLARS EXPENDED YEAR-TO-DATE FROM MAJOR FUNDING SOURCES			TOTAL YEAR-TO-DATE UNITS DELIVERED	
	COP FUNDS (Total)	FUNDS FROM OTHER SOURCES (Total)	TOTAL FUNDS	(Label Unit Type)	
V. (Continued)					
5.6 Community Based Treatment Facility	$	$	$		days
5.7 Counseling/Therapeutic Resources					days
5.8 Day Svcs/Treatment					days
VI. System Access					
6.2 Information & Referral	$	$	$		contacts/
6.4 Case Management/ Service Coordination					hours
6.5 Legal & Defense Resources					hours
6.8 Placement Assistance & Monitoring					hours
VII. Management					
7.1 Manpower Training & Development	$	$	$		
7.2 Agency/Systems Management					
VIII. Health Services: Medicare, Medicaid - NOT Included in Section V (Total units if a dollar estimate is impractical)					
1. Home Health Aide/ Private Nursing					visits
2. Therapy (PT, OT, Speech, etc)					
3. Drugs					
4. Physician					
5. Dental Care					
6. Hospitalization					days
7. Nursing Home Utilization					days
8. Other Typically Major Medicaid Services (Name)					
IX. Other (specify)					

COP YEAR-TO-DATE SERVICE DETAIL
Division of Community Services DCS-816A (2-82)

Interview Guide for
On-Site County Interviews

I would like to ask you some questions about your COP program. These questions are designed to help us understand how your program operates, how it has changed since it started, and what you feel are its strengths and weaknesses. The information you tell me will be included in the evaluation report which the Department is preparing for the legislature and other interested parties, but individual responses will not be identified. Please let me know if I ask you a question which isn't clear, if you prefer not to answer a question, or if you don't feel you have enough information to answer a question. After we have completed the interviews in each of the pilot COP counties, we will prepare a narrative summary of the findings. If you like, we could share this summary with you so that you could see if we have reported your answers correctly. Would you like to receive the summary to review?

1. ☐ Yes

☐ No

Identification

2. _____ (Name) Interviewee _____ (County)

☐ COP Coordinator (CC)

☐ Assessor/Case Plan Developer (AC)

☐ Planning Committee Chairperson (PC)

Update Plan

3. (CC) First, I am interested in your current procedures for operating your COP program. I will review parts of the plan you submitted to the Department. Please let me know if you have changed any of your policies/procedures in these areas since the plan was developed.

(Read elements of Plan. If any changes are mentioned ask why they were made.)

a) referral sources for 1982

b) schedule for gradual implementation for 1982

c) intake screening (mention if none planned)

d) client eligibility

e) who does assessment

f) who does case plan

g) who does case management/how is it done/how often?

4. Have you modified any other aspects of your program since it started? (CC)

Now I would like to ask you some questions about each of these components of your program.

Referral Process

5. Have you gotten as many referrals as you expected to get? (CC, AC, PC)

6. Have the referrals come from the type of agencies/community sources that you expected to refer clients? (CC,PC)

7. (CC, PC) Have the referrals been persons in the disability groups you expected to serve?

8. (CC,PC) Have you been able to process referrals as quickly as you expected to?

9. (CC, AC) If a person is referred, but not assessed because they don't fit your plan of implementation or aren't COP eligible, do you refer them to other agencies?

a) (CC,AC) Which agencies?

b) Has this happened yet?
(CC, AC)

Assessment

10. Do you plan to use the tool you are using for assessment next year?
(CC, AC) If not, why not?

11. Have you altered or changed your assessment tool since you started
(AC) doing COP assessments? How?

12. Are the people doing COP assessments comfortable using this tool?
(AC)

13. (AC) Do they feel it provides enough information to determine if a client is eligible for COP?

14. (AC) If a client is found <u>not</u> eligible during the assessment, is he/she referred elsewhere?

15. (AC) Has this happened yet?

16. (AC) Do the persons doing assessments feel the assessment tool provides enough information to find out what type of services a person needs to live in a community setting?

17. (AC) Are <u>clients</u> confortable with the assessment process?

18. (CC, PC) How do you know if the different people (agencies) doing assessments are using consistent criteria to complete the assessment? Have any studies been done to assess this?

19. (CC, AC) What procedures do you follow to link the assessment and case plan development for a client?

Case Plan Development

20. (CC, AC, PC) What criteria are used to determine if community services are "feasible" for a client? Who decides?

21. (CC, AC, PC) Have any clients been terminated from your COP program because services are not feasible?

22. (CC, AC) PC) What criteria do you use to determine if community services are "financially" viable for a client? (Any ceiling on total cost of services per client?) Who decides?

23. (CC, AC, PC) Have any clients been terminated from your COP program because services were too expensive?

24. (CC, AC, PC) If a client is terminated during the process of case plan development is he/she referred elsewhere?

Where?

25. (CC, AC) Have you used COP funds to develop any services that weren't available in this county before COP?

26. (CC, AC) What services?

27. (CC, AC) Have you used COP funds to expand any services that were available before?

28. (CC, AC) Which services?

29. (CC, AC) What criteria are (or will be) used to decide which services will be expanded?

30. (CC, AC) What type of client have you found most likely to be diverted by CO2?

31. (CC, AC) Are there alot of people like that in your county?

32. (CC, AC) If more than 1 agency provides a service needed by a client, how do you decide which provider to use? (criteria)

33. (CC, AC) Who makes this decision?

34. (CC, AC, PC) Do you think the case plans you've developed so far provide adequate <u>living arrangements</u> for clients?

35. If no, what changes are needed to get better living arrangements? (CC, AC, PC)

36. Do you think the case plans you've developed so far provide adequate (CC, AC, social/medical services to clients? PC)

37. If no, what changes are needed to get better services for clients? (CC, AC, PC)

Fiscal Policies

38. Do you have a cost sharing plan for COP or do you use the Uniform Fee (CC) Schedule from the Administrative Code?

39. Why did you decide to have (or not to have) a special cost sharing plan (CC, PC) for COP?

40. (CC) Do you charge for COP case management?

41. (CC) If yes, what fund/who do you charge?

42. (CC) If no, how do you cover this cost?

43. (CC, AC) How do you decide whether to use COP funds or other funds to provide clients services that were available in your county before COP?

Case Management

44. (AC) How do you decide to discontinue case management for a client diverted by COP?

45. (AC) Has this happened?

46. (AC) Do the services (the amount, the type, providers) in case plans change alot or stay the same over time?

47. (AC) What is the most frequent reason why services have to be changed?

Other Agencies

48. (CC, AC) Your plan referred to a number of other agencies that provide services which might be used by COP clients or that would be otherwise involved in the COP program by carrying out certain activities such as generating referrals, doing assessments, etc.

I would like to review that list of agencies and for each find out 1) what the agency's involvement has been to date; 2) what type of COP training or dissemination of information has been offered to the agency staff; and 3) what changes, if any, have taken place in the agency's policies/procedures to serve COP clients or to carry-out COP program activities.

Agency	Role/Training	Changes in Policies/Procedures

49. (CC, AC, PC) Coordination between medical and social service agencies is often difficult because of the different training, perspectives, and responsibilities involved. Do you feel that your COP program has adequate communication with local hospitals, nursing homes, clients' physicians?

a) hospitals

b) nursing homes

c) clients' physicians

50. (CC, AC, PC) What type of communication typically occurs between lead agency staff and hospitals/nursing home staff, physicians. (Who talks to who, about what, how often?)

a) hospitals

b) nursing homes

c) clients' physicians

51. (CC, AC, PC) How do you think communication with the above could be improved?

Planning Committee

52. (CC, PC) I would like to learn more about how your COP Planning Committee functions. What types of policies has the Planning Committee made? (Examples of possible policy decisions would be deciding type of clients to be served, which agencies do assessments, interagency argreements, etc.)

53. (CC, PC) Do you feel these are advice to the lead agency or that they are directives which must be acted on?

54. (CC, PC) Does the Planning Committee make any decisions affecting administration of the program such as qualifications of staff, staff roles, procedures for billing etc.?

55. (CC, PC) How does the Planning Committee monitor program implementation? (Get copies of reports to Planning Committee.)

56. (CC, PC) Are you satisfied with the role of the Planning Committee or do you think it should be changed, strengthened, weakened?

Strengths/Weaknesses

58. (CC, AC, PC) What has been the most difficult part of initiating your COP program?

59. (CC, AC, PC) How could other counties avoid these difficulties?

60. (CC, AC, PC) What part of program start-up has worked out the best?

61. (CC, AC, PC) Why did this work so well?

Indirect Effects

62. (CC, AC, PC) What effect, if any, has the COP program had on the lead agency or other agencies, groups in the community?

Miscellaneous

63. (CC, AC, PC) Is there anything else about your program that you would like to tell me about?

GK:bu/48
9/23/82

Client Name: _____
Phone Number: _____
Guardian Name: _____
County Number: _____
Client Number: _____

Phone Survey:
COP Client Satisfaction Survey

Hello. Is this (client's name)?

My name is (your name) from the Wisconsin Department of Health and Social Services.

You have been receiving some services through the (name of county) county (social services/human services) Department.

I'd like to ask you some questions on your opinion about the services. Your participation, of course, is voluntary and you are free to refuse to answer any questions. Your name won't be disclosed and this survey in no way affects your eligibility for the services.

The questions take about 15 minutes. Do you have time to answer the questions now or should I call back at another time?

If call back:

Time: _____
Date: _____

1. Could you tell me about when you <u>first seriously</u> considered entering a nursing home?

   Month _____ Year _____

   (If unable to give month and year)

   Was it within the last 6 months, 6 months to a year ago, 1-2 years ago or more than 2 years ago?

   _____ (1) within last 6 months
   _____ (2) 6 months to 1 year ago
   _____ (3) 1-2 years ago
   _____ (4) more than 2 years ago

2. Was there a particularly memorable event or incident that caused you <u>first</u> to think seriously about entering a nursing home? Like an accident, illness, the death of someone close to you?

   _____ (1) Yes _____ (2) No

3. (IF YES), what was the event or incident?

_____

_____

4. When did this happen?

Month _____ Year _____

(If unable to give month and year) Was it within the last 6 months, from 6 months to a year ago, 1 to 2 years ago or more than 2 years ago?

_____ (1) within last 6 months
_____ (2) 6 months to 1 year ago
_____ (3) 1-2 years ago
_____ (4) more than 2 years ago

5. When you <u>first seriously</u> considered entering a nursing home, did your family or friends make any special arrangements to make sure you didn't have to enter a nursing home?

_____ (1) Yes _____ (2) No

6. (IF YES,) what kinds of things did they do?

a. Did they <u>themselves</u> start helping you more with housework, cooking, transportation, financial affairs, medical care or other things?

_____ (1) housework
_____ (1) cooking
_____ (1) transportation
_____ (1) financial affairs
_____ (1) medical care
_____ (1) other things _____
_____ (1) _____
_____ (1) _____

b. Did they arrange for <u>someone else</u> to help you with housework, cooking, transportation, financial affairs, medical care or other things?

_____ (1) housework
_____ (1) cooking
_____ (1) transportation
_____ (1) financial affairs
_____ (1) medical care
_____ (1) other things _____
_____ (1) _____
_____ (1) _____

Now I'm going to ask you some questions about the services you receive.

7. According to the county, you receive (List from plan. Describe service if necessary.)

A _____
B _____
C _____
D _____

(Use additional sheets if necessary.)

Are there any of those I read that you never received?

_____ (1) Yes _____ (2) No, received them all (Skip to Q 9)

8. (IF YES), which ones didn't you receive? (offer to read list again)

_____ (1) A
_____ (1) B
_____ (1) C
_____ (1) D

(Complete Questions 9-12 only for those services the client reports actually receiving.)

9. a. For (Service A), how would you rate the quality? Was it generally good or bad?

_____ (1) Good _____ (2) Bad

b. Did you get about the right amount of that service, or do you think you got too much or not enough?

_____ (1) right amount _____ (2) too much _____ (3) not enough

10. a. For (Service B), how would you rate the quality? Was it generally good or bad?

_____ (1) Good _____ (2) Bad

b. Did you get about the right amount of that service, or do you think you got too much or not enough?

_____ (1) right amount _____ (2) too much _____ (3) not enough

11. a. For (Service C), how would you rate the quality? Was it generally good or bad?

_____ (1) Good _____ (2) Bad

b. Did you get about the right amount of that service, or do you think you got too much or not enough?

_____ (1) right amount _____ (2) too much _____ (3) not enough

12. a. For (Service D), how would you rate the quality? Was it generally good or bad?

_____ (1) Good _____ (2) Bad

b. Did you get about the right amount of that service, or do you think you got too much or not enough?

_____ (1) right amount _____ (2) too much _____ (3) not enough

13. Did you get the types of services you wanted?

_____ (1) Yes _____ (2) No

14. Do the services generally meet your needs?

_____ (1) Yes _____ (2) No

15. If a friend needed similar help, would you recommend the same services?

_____ (1) Yes _____ (2) No

16. Have the services helped you with your problems?

_____ (1) Yes _____ (2) No

17. Overall, how satisfied are you with the services? Are you generally satisfied or dissatisfied?

_____ (1) Satisfied _____ (2) Dissatisfied

18. If you needed help again, would you go back to the same agency?

_____ (1) Yes _____ (2) No

19. Going back to when you were discussing the possibility of arranging for services that would allow you to avoid entering the nursing home, do you remember someone from the County (Social Services/Human Services) Department assessing your needs?
___ (1) Yes ___ (2) No

20. a. (IF YES), how did you feel about that assessment? Did the person or persons doing the assessment ask the right kinds of questions?

___ (1) Yes ___ (2) No

b. Were there too many questions?

___ (1) Yes ___ (2) No

c. Were the questions too personal?

___ (1) Yes ___ (2) No

Thank you very much for your time. Goodbye.

INTERVIEWER COMPLETE

Interviewer's comments:

RB:jt/1
11/18/82

Client Name: _____
Guardian Name: _____
Phone Number: _____
County Number: _____
Client Number: _____

Phone Survey:
Why Do Clients Turn Down Services?

Hello. Is this (client's name)?

My name is (your name) from the Wisconsin Department of Health and Social Services. We're looking at a number of social and medical services to find out how well they meet people's needs and whether some improvements are needed.

Earlier this year, your (relationship), (client's name), entered a nursing home. Just before (s/he) entered the nursing home, someone from the County (Social Services/Human Services) Department discussed with (him/her) the possibility of arranging for a number of services that would allow (him/her) to avoid entering the nursing home.

We understand that (s/he) turned down that offer of services and chose instead to enter the nursing home. Did (s/he) enter a nursing home? (If NO, skip to Point A.)

I'd like to ask you some questions about why your (relationship) entered the nursing home. Your participation, of course, is voluntary and you are free to refuse to answer any questions. We won't disclose your name or your (relationship's) name, and this survey in no way affects your (relationship's) eligibility for services.

The questions take about 15 minutes. Do you have time to answer the questions now or should I call back another time?

If call back:
Time: _____
Date: _____

1. Could you tell me about when your (relationship) first seriously considered entering a nursing home?

   Month _____ Year _____

   (If unable to give month and year)

   Was it within the last 6 months, 6 months to a year ago, 1-2 years ago or more than 2 years ago?

   _____ (1) within last 6 months
   _____ (2) 6 months to 1 year ago
   _____ (3) 1-2 years ago
   _____ (4) more than 2 years ago

2. Was there a particularly memorable event or incident that caused (him/her) first to think seriously about entering a nursing home? Like an accident, illness, the death of someone close to (him/her)?

_____ (1) Yes _____ (2) No

3. (IF YES), what was the event or incident?

_____

_____

4. When did that happen?

Month _____ Year _____

(If unable to give month and year)

Was it within the last 6 months, from 6 months to a year ago, 1 to 2 years ago or more than 2 years ago?

_____ (1) within last 6 months
_____ (2) 6 months to 1 year ago
_____ (3) 1-2 years ago
_____ (4) more than 2 years ago

5. When (s/he) first seriously considered entering a nursing home, did (his/her) family or friends make any special arrangements to make sure (s/he) didn't have to enter a nursing home?

_____ (1) Yes _____ (2) No

6. (IF YES,) what kinds of things did they do?

a. Did they themselves start helping (him/her) more with housework, cooking, transportation, financial affairs, medical care or other things?

_____ (1) housework
_____ (1) cooking
_____ (1) transportation
_____ (1) financial affairs
_____ (1) medical care
_____ (1) other things _____
_____ (1) other things _____
_____ (1) other things _____

b. Did they arrange for someone else to help (him/her) with housework, cooking, transportation, financial affairs, medical care or other things?

_____ (1) housework
_____ (1) cooking
_____ (1) transportation
_____ (1) financial affairs
_____ (1) medical care
_____ (1) other things _____
_____ (1) other things _____
_____ (1) other things _____

Now I'm going to ask you a number of questions about why your (relationship) chose to enter the nursing home. Please think back to when (s/he) finally made the decision to move to the nursing home and tell me whether the reason I'll read was true in (his/her) case.

First, did (s/he) enter the nursing home because someone else wanted (him/her) to? Like a family member, your doctor or a friend?

7. Family member ____ (1) Yes ____ (2) No

8. Your doctor ____ (1) Yes ____ (2) No

9. A friend ____ (1) Yes ____ (2) No

10. Did (s/he) enter the nursing home because (s/he) want to be independent of (his/her) family? ____ (1) Yes ____ (2) No

11. Did (s/he) feel (s/he) needed the services offered in the nursing home? ____ (1) Yes ____ (2) No

12. Did (s/he) enter the nursing home because (s/he) felt life would be easier in the nursing home? ____ (1) Yes ____ (2) No

13. Was (s/he) afraid (s/he) couldn't get emergency medical help if (s/he) didn't enter the nursing home? ____ (1) Yes ____ (2) No

14. Did (s/he) enter the nursing home because (s/he) want to be around other people? ____ (1) Yes ____ (2) No

15. Did (s/he) enter the nursing home because (s/he) couldn't get around well? ____ (1) Yes ____ (2) No

16. Was (s/he) afraid of being a victim of crime if (s/he) didn't enter the nursing home? ____ (1) Yes ____ (2) No

17. Did (s/he) enter the nursing home because (s/he) thought it would be less lonely? ____ (1) Yes ____ (2) No

18. Did (s/he) enter the nursing home because it was difficult for (him/her) to do housework? ____ (1) Yes ____ (2) No

19. Did (s/he) enter the nursing home because (s/he) had friends or relative there and wanted to be with them? ____ (1) Yes ____ (2) No

20. Did (s/he) enter the nursing home because (s/he) felt like (s/he) would be a burden on others if (s/he) didn't? ____ (1) Yes ____ (2) No

21. Did (s/he) enter the nursing home because (s/he) didn't want welfare services? ____ (1) Yes ____ (2) No

22. Did (s/he) enter the nursing home because it was too difficult for (him/her) to prepare meals? ____ (1) Yes ____ (2) No

23. Were there any other reasons that I <u>didn't</u> mention why (s/he) chose to enter the nursing home? (list) ____ (1) Yes ____ (2) No

___
___
___
___

24. Do you think (s/he) made the right choice to enter the nursing home? ____ (1) Yes ____ (2) No

25. Going back to when your (relationship) were discussing the possibility of arranging for services that would allow (him/her) to avoid entering the nursing home, do you remember someone from the County (Social Services/Human Services) Department assessing (his/her) needs? ____ (1) Yes ____ (2) No

26. a. (IF YES), how did you feel about that assessment? Did the person or persons doing the assessment ask the right kinds of questions? ____ (1) Yes ____ (2) No

b. Were there too many questions? ____ (1) Yes ____ (2) No

c. Were the questions too personal? ____ (1) Yes ____ (2) No

Thank you very much for your time. Good bye.

___

Interviewer's comments:

Point A: I'm sorry. Our information indicated (s/he) had entered a nursing home. Since (s/he) didn't, our questions won't make sense, so we won't go on with the survey. Thank you very much for your time. Good bye.

RB:jt/38
11/15/82

TYPE OR PLACE ON HARD SURFACE - WRITE LEGIBLY AND FIRMLY

To Be Completed By State Agency	Agency Action: Care Level Rev'd By: _____ Eff. Date _____

MA PATIENT MEDICAL PLAN OF CARE EVALUATION AND REFERRAL FORM

PART A — TO BE COMPLETED BY DISCHARGING FACILITY

Patient Name _____
Last First Middle Initial

Address _____
City County Zip

Age	Birthdate	Sex M F	Marital Status S M W D Sep.	Religion

Medicare No. & Letter	Plan A B	Social Security No.

Medicaid or SSI No.	Other Insurance

Resp. Relative or Guardian _____ Relationship _____

Address _____ Tele. No. _____

Attending Physician _____

Discharged From _____
Hospital Home Other Facility

Address _____

Hosp. Adm. Date Disch. Date Hosp. Telephone No.

Facility Admitted To _____ Date _____

Address _____

Reason For Plan of Care (check one):

New Admission To Facility____ Readmission____
MA Eligibility Established While In Facility____ Date_____
Current Care Level____ Re-evaluation Request: ___
Effective Date_____

TO BE COMPLETED BY PHYSICIAN

PHYSICIAN PLAN OF CARE

Directions: Items 1-2 may be deleted if attached in narrative form.

1. PHYSICIAN PLAN OF CARE: (copies are to be attached of curr. phys. exam, chest x-ray, and discharge summary)
   A. Course of treatment including medical/surgical procedures done and date: _____

   B. Diagnoses: (Admitting, discharging, and long-term) _____

2. PHYSICIAN'S ORDERS: Include specific orders for medications, diag. tests, activities, act. level, special diet, special treatments, including PT, OT, SPT; (specify freq. per week) _____

3. RECOMMENDATION FOR PATIENT PLACEMENT:
   ☐ Skilled Nursing Facility (see def. on back)
   ☐ Intermediate Care Facility (see def. on back)
   ☐ ICF-1 ☐ ICF-2 ☐ ICF-3 ☐ ICF-4)
   ☐ Community Based Residential Facility (CBRF)
   ☐ Other, specify: _____

4. TREATMENT GOALS AND PROGNOSIS:
   A. Short stay of ____ months with rehabilitation leading to discharge home/or other facility.
   B. Rehabilitation potential/prognosis (describe the highest level of functioning pt. can be expected to achieve.)
   C. Long term care _____.

I certify that this patient's medical conditions and related needs are essentially as indicated above, and that inpatient care is necessary. I also certify that this patient is free of communicable disease.

Physician's Signature _____ Date _____ Telephone No. _____

Copies to: Orig.-Rec'ing. Facility (1)Copy-DOH DO (2)Copy-Co. of Fac. Locat. (3)Copy-Dischargin Fac. (medical records)
White White White

BEST COPY AVAILABLE

BEST COPY AVAILABLE

DOH-3032 12/81

Patient's Name _____ MC/MA No. _____

PART C — TO BE COMPLETED BY REGISTERED NURSE

PATIENT CARE PLAN

NURSING: Self-Care Status Check Func. Level		Indep.	Unable	Needs Assist.	Comments
Ambulation	Bed-Chair				
	Walking				
	Stairs				
	Wheelchair				
	Crutches				
	Walker				
	Cane				
Activities	Bathe self				
	Dress self				
	Feed self				
	Brush teeth				
	Shaving				
	Toilet				
	Commode				
	Bedpan/Urinal				

Incontinence: ☐ Bladder ☐ Bowel

Bowel & Bladder Program ☐ Yes ☐ No

Catheter: Type _____ Date last changed: _____

Vital Signs: T _____ P _____ R _____ BP _____

Weight _____ Height _____ Date _____

Check If Pertinent: Describe in patient care plan

DISABILITIES
__ Amputation
__ Paralysis
__ Contracture
__ Decubitus
__ Ostomy
__ Other
_____

BEHAVIOR
__ Oriented
__ Forgetful
__ Noisy
__ Confused
__ Withdrawn
__ Wanders
__ Combative

COMMUNICATION
__ Can Write
__ Talks
__ Understands Speaking
__ Understands English
__ Language Barrier
__ Reads
__ Nonverbal

IMPAIRMENTS
__ Speech
__ Hearing
__ Vision
__ Sensation
__ Other

APPLIANCES/PROSTHESIS
Check "S" if sent; "N" if needed.
__ Cane
__ Crutches
__ Walker
__ Wheelchair
__ Other _____
__ Dentures
__ Eye Glasses
__ Hearing Aid
__ Prosthesis (type)

Comments: _____

PATIENT CARE PLAN

Describe details of care; sp. prob./approaches rel. to administ. of medicat./treatments, skin condition, teaching done or needed, level of patient understanding, motivation, communications, restraints, diet, allergies;

(Attach additional page if necessary)

I certify the above information is current and correct to the best of my knowledge. Date _____ Tele. No. _____

_____ R.N. Signature

Copies attached: __Phys. & Chest X-Ray __Discharge Summary __Prog. Notes __PT, __OT, __SP __Dietary

PART D — TO BE COMPLETED BY SOCIAL WORKER (WHERE AVAILABLE)

SOCIAL SERVICE

Prior to present, pt. lived: __With Family __With Friends __Alone __Nursing Home __Other _____

SOCIAL INFORMATION (Include info. re. patient's attitude, person., family constell./inter-relat.)

Present Situation: (short/long range social service plans) _____

Social Worker Signature _____ Date _____ (Attach Social Summary if nec.) Telephone No. _____

Copies to: Orig.-Rec'ing. Facility (1)Copy-DOH DO (2)Copy-Co. of Fac. Locat. (3)Copy-Discharging Fac. (medical records)
White White White

APPENDIX B

Statutory Language

46.27 Long-term support community options program. (1) DEFINITIONS. In this section:

(a) "Hospital" has the meaning provided in s. 50.33 (1).

(b) "Nursing home" has the meaning provided in s. 50.01 (3).

(c) "Program" means the long-term support community options program.

(2) DEPARTMENTAL DUTIES. The department shall:

(b) Coordinate the program with:

1. Discharge planning from hospitals;

2. Independent medical reviews and professional reviews established under 42 USC 1396a (a) (31); and

3. The protective service system under ch. 55.

(c) Review and approve or disapprove the selection of a county agency under sub. (3) (b) to administer the program.

(d) In consultation with representatives of counties, hospitals and nursing homes and with recipients of long-term community support services, develop guidelines for implementing the program and criteria for reviewing community options plans from counties participating in the program. The guidelines and criteria shall address cost-effectiveness, scope, feasibility and impact on the quality and appropriateness of health and social services and shall provide counties with maximum flexibility to develop programs that address local needs.

(e) Review and approve or disapprove the community options plan of each county participating in the program. To the extent practicable, the department shall also seek to have a cross section of counties participating in the program.

(f) Evaluate the cost-effectiveness of the program and the ability of the program to provide alternatives to institutional care of persons.

(3) DUTIES OF PARTICIPATING COUNTIES. The county board of supervisors of any county participating in the program shall:

(a) Create an interagency long-term support planning committee, with the composition and the duties specified under sub. (4).

(b) Designate one of the following agencies, subject to departmental review and approval, to administer the program:

1. A county department of social services or public welfare;

2. A combined community services board with the powers and duties specified in ss. 51.42 and 51.437; or

3. A community human services board created under s. 46.23.

(c) Develop procedures and phases for gradual implementation of this section in accordance with guidelines and criteria the department develops under sub. (2) (d).

(cm) Review and approve, disapprove or amend a community options plan to participate in the program, prior to submitting the plan to the department.

(d) Ensure that the program uses existing county resources and personnel to the greatest extent practicable and enhances the effectiveness of discharge planning from hospitals.

(4) PLANNING COMMITTEE. (a) The county board of supervisors shall select the county long-term support planning committee, which shall include at a minimum the following members:

1. At least 2 persons receiving long-term community support services;

2. One elected county official;

3. One county health representative;

4. One representative of the county department of social services or public welfare;

5. One representative of the community boards created under s. 51.42 or 51.437; and

6. One representative of the county commission on aging.

(b) If practicable, the county board shall select a physically disabled person as one of the members of the planning committee under par. (a).

(c) The planning committee shall develop a community options plan as an addendum to the coordinated plan and budget under s. 46.031 for participation in the program. The plan shall include:

1. A description of the county's proposed program, including the estimated numbers of persons to be assessed and the procedures to be used in performing assessments.

2. A description of the services available and the services to be developed or expanded as alternatives to institutional care under this program.

3. A description of the procedures to be used to coordinate the program with other county agencies, hospitals, nursing homes and providers of community support services.

4. A description of the method to be used to coordinate the use of funds received under this program with the use of other funds allocated to the county under ss. 46.80 (5) and 49.52 (1) (d) and to community mental health boards under s. 51.42 (8).

5. A description of the method to be used by the committee to monitor the implementation of the program.

(5) AGENCY DUTIES. The agency selected by the county board of supervisors to administer the program shall:

(am) Organize assessment activities specified in sub. (6). The agency shall utilize persons for each assessment who can determine the needs of the person being assessed and who know the availability within the county of services alternative to placement in a nursing home or in a state center for the developmentally disabled. If any hospital patient is referred to a nursing home for admission, these persons shall work with the hospital discharge planner in performing the activities specified in sub. (6). The agency shall coordinate the involvement of representatives from the county department of social services or public welfare, community boards created under s. 51.42 or 51.437, health service providers and the county commission on aging in the assessment activities specified in sub. (6), as well as the person being assessed and members of the person's family or the person's guardian.

(b) Within the limits of state and federal funds allocated under sub. (7), arrange service contracts under s. 46.036 and ensure the provision of necessary long-term community support services for each person who meets the criteria specified in sub. (6) (b).

(c) Within the limits of state and federal funds allocated under sub. (7), provide for ongoing case management, periodic case plan review and follow-up services for any person receiving long-term community support services under sub. (6) (b).

(d) 1. Apply the uniform fee schedule under s. 46.03 (18) for long-term community support services provided any person under par. (b), if the person is eligible for medical assistance under s. 49.46 or 49.47 or if the agency finds the person likely to become medically indigent within 6 months by spending excess income for medical or remedial care.

2. Bill other persons not subject to subd. 1 for the full cost of long-term community support services received.

3. Use funds received under this paragraph to pay for long-term community support services.

(e) Within the limits of state and federal funds allocated under sub. (7) and in accordance with the county's plan for gradual implementation, apply the program to any person residing in a nursing home or state center for the developmentally disabled who wants to be assessed and to receive long-term community support services, and coordinate the program with the protective services system under ch. 55.

(6) ASSESSMENTS. (a) 1. Within the limits of state and federal funds allocated under sub. (7), an assessment shall be conducted for any person seeking admission to or about to be admitted to a nursing home in participating counties, or to a state center for the developmentally disabled for extended care placement if the person's county of residence is participating in this program. The assessment shall determine the person's functional abilities, disabilities and need for medical and social long-term community support services. Each assessment shall include an investigation of long-term community support services that could serve as alternatives to institutional placement in a nursing home or in a state center for the developmentally disabled. The assessment shall include an explanation of the alternatives to the person being assessed and the person's family or guardian.

2. Assessment procedures under this paragraph do not apply to any person seeking admission to a nursing home or state center for the developmentally disabled that is excluded because of gradual implementation of the program under sub. (3) (c). Assessment procedures under this paragraph do not apply in emergencies, as determined by a physician, but shall be applied within 10 days of admission. Private pay patients may waive the assessment procedures under this paragraph unless the patient will be eligible for medical assistance within 6 months of assessment.

3. In each participating county, assessments shall be conducted for those persons and in accordance with the procedures described in the county's community options plan. The county may elect to establish assessment priorities for persons in target groups identified by the county in its plan regarding gradual implementation. The county may also elect to assess persons already admitted to nursing homes and eligible for medical assistance.

4. If an assessment indicates that a person needs nursing home care, the assessment shall determine the degree of need for this care. Vetoed in Part

(b) Within the limits of state and federal funds allocated under sub. (7), a community services case plan shall be developed for any person with chronic disabilities:

1. Who is assessed under par. (a); and

2. For whom noninstitutional community services are feasible, financially viable and preferred by the person or the person's guardian. In this subdivision, noninstitutional community services are financially viable if they can be financed by state or federal funds allocated under sub. (7).

(c) 1. If an assessment determines that nursing home care is not appropriate for a person who is eligible for medical assistance or who will be eligible within 6 months and if state or federal funds are available to support any needed noninstitutional services for the person in the community, then medical assistance reimbursement is not available for nursing home services provided to the person. An assessment determination that nursing home care is not appropriate supersedes a physician's plan of care authorizing nursing home care if the assessment determination includes review by a physician. An aggrieved person may appeal the assessment decision under ss. 49.45 (5) and 49.50 (8).

2. This paragraph applies only to counties that have fully implemented the program.

(7) FUNDING. (a) From the appropriation under s. 20.435 (2) (b), the department shall allocate $152,200 for 1982 and $503,900 for the first 6 months of 1983 to pay assessment and case plan costs under sub. (6) not otherwise paid under s. 46.032 or 49.45. The department shall reimburse counties for the cost of assessing persons eligible for medical assistance under s. 49.46 or 49.47 as part of the administrative services of medical assistance, payable under s. 49.45 (3) (a). Counties may use unspent funds allocated under this paragraph to pay the cost of long-term community support services.

(b) 1. From the appropriation under s. 20.435 (2) (b), the department shall allocate $649,200 for 1982 and $1,677,900 for the first 6 months of 1983 to pay the cost of providing long-term community support services under sub. (5) (b) to persons eligible for medical assistance under s. 49.46 or 49.47 or to persons whom the agency administering the program finds likely to become medically indigent within 6 months by spending excess income for medical or remedial care. The average per person reimbursement under this paragraph may not exceed 42% of the average per person reimbursement rate the department expects under s. 49.45 (6m). The agency administering the program may spend funds received under this paragraph only in accordance with the case plan and service contract created for each person receiving long-term community support services.

2. No county may use funds received under this paragraph to pay for long-term community support services provided any person who resides in a nursing home or state center for the developmentally disabled, unless the department waives this restriction on use of funds and the services are provided in accordance with a discharge plan.

(c) 1. The department shall allocate funds under this section to participating counties according to each county's proportionate share of a 3-factor formula, based equally on each county's percentage of the state's average monthly medical assistance population during the period of February 1978 to July 1978, each county's ranking on an urban-rural scale, which is to be determined based on the county's percentage of population living in cities, towns or villages with populations of 2,500 or more, and each county's ranking as determined by the ratio of the 1977 full value of all taxable property in the county, as defined in s. 70.57, to the county's 1977 population. No county may receive more than 50% of the total funds available in 1982 and, for the first 6 months of 1983, no county may receive less than the funds received in 1982.

2. Receipt of funds under this section is subject to s. 49.52 (2).

3. The department may not release funds under this section before approving the county's community options plan.

(d) The department may release funds to counties acting jointly, if the counties sign a contract approved by the secretary that explains the plans for joint sponsorship.

(e) No county may use funds received under this section to:

1. Purchase land or construct buildings;

2. Replace federal, state or county matching funds for long-term community support services previously provided, as indicated by the prior year's coordinated plan and budget, except to the extent that federal or state funding available for these services decreases; or

3. Reduce the federal, state or county matching expenditures for long-term community support services provided to any person under sub. (5) (b) from funds allocated under s. 46.80 (5), 49.52 (1) (d) or 51.42 (8), except to the extent that federal or state funding allocated under these sections decreases.

(8) COUNTY PARTICIPATION. Beginning January 1, 1982, the department may accept as participants in the program up to 8 counties that elect to comply with this section. Beginning January 1, 1983, this section continues to apply to counties participating in the program in 1982. In addition, any county within which resides more than one percent of the state's nursing home population, excluding residents of state centers for the developmentally disabled, may elect to participate in the program beginning January 1, 1983. The department may accept these additional counties until the total number of nursing home residents in all participating counties equals 70% of the state's nursing home population, excluding residents of state centers for the developmentally disabled. On or after September 1, 1982, the department may designate other counties it will require to participate in the program in 1983 subject to the condition that the total number of nursing home residents in all participating counties may not exceed 70% of the state's nursing home population, excluding residents of state centers for the developmentally disabled, and subject to approval or modification of the joint committee on finance. The department shall notify the joint committee on finance of the counties it proposes to designate. If the joint committee on finance fails to schedule a public hearing or executive session to review the proposed designation within 21 days after receiving notice, the committee is deemed to have approved the designation.

50.04 (2m) (title) PLAN OF CARE AND ASSESSMENT REQUIRED. No nursing home may admit any patient until a physician has completed a plan of care for the patient and the patient is assessed under s. 46.27 (6) (a). Failure to comply with this subsection is a class "B" violation under sub. (4) (b) 2.

APPENDIX C

SUMMARY, DESCRIPTION AND EVALUATION FINDINGS FROM
SELECTED PROGRAMS REVIEWED IN DEVELOPING
THE COMMUNITY OPTIONS PROGRAM

Project: Virginia Nursing Home Pre-Admission Screening Program

Abstract: The Virginia pre-admission screening program was initiated in 1977. Persons screened under the program include those who are Medicaid-eligible or who are expected to become Medicaid-eligible within ninety days of nursing home admission. Screening is required prior to authorizing Medicaid payment for nursing home care. The screening is done by a team including a public health physician, a public health nurse, and a social worker. Potential nursing home admissions from state mental health/retardation facilities are screened by a central pre-admission screening committee within the state department of health. Screening also includes indentifying the services in the community needed to meet the needs of the persons screened.

Findings:

1. Between May of 1977 and June of 1980, twenty percent of the persons screened were not recommended for nursing home placement.

2. The proportion of persons screened who were not recommended for placement varied by regions within the state, possibly related to the availability of community resources.

3. A survey of 170 persons screened between April and September 30 of 1978 showed that only ten of the eighty-eight who were not recommended for nursing home placement had entered nursing homes between December 1, 1978 and January 12 of 1979 when the survey was conducted.

4. Family members were found to be providing care that enabled the person to live in the community in slightly over half of the eighty-eight cases not recommended for nursing home placement.

5. Definitive data on cost were unavailable.

Source: Jackson Knowlton, et. al. "Nursing Home Pre-Admission Screening: A Review of State Programs," Health Care Financing Review, Vol. 3. No. 3. March 1982.

Project: ACCESS: Monroe County New York Long Term Care Program

Abstract: ACCESS started in December of 1977. Persons served include residents of Monroe County, eighteen years or older, who needed home-based or institutional long-term care. All Medicaid-eligible clients were required to be referred to ACCESS and non-Medicaid clients were assessed free. Services included assessment, service plan development, contacting providers to arrange services, follow-up and monitoring of services. Case plans were developed for private payed persons, but these persons pay for services on their own. (ACCESS did however, provide financial counseling to private pay.) Medicaid waivers allowed a number of community-based social services to be offered to Medicaid-eligible clients. To receive services, services were to be no more than 75 percent of the cost of institutional services for an equivalent level of care. Plans costing more than this were referred to Medicaid for approval. The program was funded as a Section 222 Medicare project for three years. Currently it is operating through county support.

Findings

1. Over half of the clients referred to ACCESS are private pay, but it cannot be determined to what extent they follow their case plans.

2. The percent of assessments that are MA eligible declined from 47 percent in 1978 to 42 percent in the first six months of 1980, suggesting that future project growth will be in the private sector.

3. The project operation during the first 28 months showed the percent of referrals placed at home increased over time and that Medicaid-eligible referrals and referrals from the community (rather than hospitals) were more likely to be placed at home. Of the skilled care patients served January through July of 1980, 96 percent of the Medicaid and 88 percent of the private pay community referrals were placed at home, whereas 54 percent of the Medicaid and 25 percent of the private pay hospital referrals were placed at home. (Approximately 60 percent of the community and 80 percent of the hospital referrals were rated skilled care.)

4. In Monroe County, Medicaid utilization fell by more than private utilization increased. A mixed pattern emerged regarding similar comparisons in six other comparison counties. The value of these comparisons is unclear, however, because the comparison counties were unlike Monroe County on selected demand and supply variables which could be expected to affect utilization.

5. Hospital back-up days in Monroe County increased consistently from the first quarter of 1977 through the second quarter of 1980. It is not clear that this was due to ACCESS because no comparison county data was available.

6. The rate of change in total Medicaid medical expenditures (excluding ACCESS MA waiver services) for the aged showed mixed results. Increases in Monroe County were lower than those in all but one of the six comparison counties in 1977-78, but greater than that in all but two of the six comparison counties in 1978-79.[1]

7. A comparison of pre- and post-ACCESS project period Medicaid expenditures of all clients, not just the aged, showed that total expenditures rose in Monroe County by 17.5 percent and by between 21.6 and 43.2 percent in the other six counties. The lower rate of increase in Monroe County appeared attributable to a much lower rate of increase in nursing home expenditures. This, however, may have in turn been due to the closing of 77 nursing home beds in a heavily Medicaid nursing home in Monroe County.

Source: Margaret Stassen and John Holahan, Long Term Care Demonstration Projects: A Review of Recent Evaluations, The Urban Institute, February 1981.

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[1] During this time, average monthly expenditures and average dollars per person were substantially lower in Monroe than in the comparison counties but this effect was probably offset by the substantially larger increases in the number of persons served in Monroe versus in the comparison counties.

Project: COMMUNITY-BASED CARE (CBC) SYSTEMS For The Functionally Disabled, Washington

Abstract: The CBC project demonstration operated in 1977 and 1978. Persons targeted for services were aged and physically disabled individuals at risk of nursing home placement in three to six months or persons in nursing homes no longer needing that level of care. The OARS Multidimensional Functional Assessment Questionnaire (Duke University) was used to assess risk of nursing home placement. Services offered by the project included assessment by an interdisciplinary team, service coordination, case management, and follow-up case monitoring. Service packages exceeding the cost of institutional care were only permitted if they were expected to generate long-run savings.

Findings

1. Many project clients were found after the fact not to have been candidates for nursing home care indicating it is difficult to identify persons for whom community-based care will actually substitute for nursing home care.

2. Over 22 months, nursing home utilization declined in the two experimental sites more than in the comparison site or in balance of the state. This difference however may have been due to other factors such as differential changes in nursing home bed supply which were not included in the analyses.

3. Client referral procedures and development of the provider network made it possible to manipulate average or per capita use of particular services.

4. Total public costs increased in both experimental sites more than they were expected to increase based on projected values computed from the data in the control site. The analysis did not include publicly funded private payments (SSI, food stamps etc.) that also may have been used to support community-based care and was limited by failing to control for other factors which may have contributed to observed findings.

5. The increase in total system costs appeared primarily due to an increase in the caseload for community-based services and an increase in the case management costs incurred to support the multi-disciplinary team.

6. The per capita cost of community care for clients - even those with similar impairment scores as those of actual nursing home residents - was less than the "break even" amounts of approximately $285 and $291, which were calculated to reflect the point at which maintaining a client in the two experimental site communities would be equal to that of maintaining a client in a nursing home. This however may not imply that community care is cheaper than nursing care because it is not known how many of the community care clients would actually have entered a nursing home. Cost differentials may also be attributed to the fact that most of the community care clients did not need or did not receive the full range of supportive and nursing services provided in a nursing home.

Source: Margaret Stassen, et. al. Long-Term Care Demonstration Projects: A Review of Recent Evaluations, The Urban Institute, February 1981,
and
Robert A. Salem, et. al. Community-Based Care Systems For The Functionally Disabled, A Project In Independent Living. Washington Department of Social and Health Services, July 1979.

Project: Georgia's Alternative Health Services Project

Abstract: Georgia's Alternative Health Services Project started to operate in July of 1976 in 17 contiguous counties in Georgia. Project services began to be offered as part of the state's regular Medicaid program in August of 1980. Persons served included those Medicaid-eligibles referred who were age 50 or over, eligible for nursing home care, and judged appropriate for project services by the assessment team and who consented to receive services. The types of services offered included: alternative living arrangements, adult day rehabilitation, and home delivered health and social services. Clients whose service needs exceeded those approximately equal to the monthly cost to the state of ICF care would usually be considered not appropriate as would those able to live independently without project services.

Findings:

1. Outpatient hospital, regular Medicaid or Medicare home health and other service costs were similar for the randomly assigned experimental and control group. Drug costs were higher in the control group. Physician costs and nursing home costs were lower for the experimental group although the differences were not statistically significant.

2. The death rate was higher in the control group.

3. There was no evidence to indicate the quality of life was lower among survivors in the experimental group.

4. The average total monthly Medicaid plus Medicare costs were higher ($90/mo.) for the experimentals than for the controls. The public costs associated with screening and case management were excluded from analysis.

5. When the analysis of total average monthly Medicaid plus Medicare expenditures was limited to a subsample of clients judged most at risk of entering a nursing home (those recommended for alternative living services), costs for experimentals were found to be $31/month less than that for controls. The difference was not statistically significant.

6. It appeared probable that the voluntary provision of services to individuals who were eligible for nursing home care resulted in many clients not at risk of entering a nursing home receiving add-on services, instead of substituting services for nursing home care.

Source: F. Albert Skellie Ph.D., et. al, "Cost-Effectiveness of Community-Based Long-Term Care: Current Findings of Georgia's Alternative Health Services Project." American Journal of Public Health, April 1982, Vol. 72, No. 4.

Project: TRIAGE: Coordinated Service Delivery of Services to Elderly

Abstract: Triage operated from February 1974 to September 1981 in a 7-town area of Connecticut. From February 1974 through March of 1979 it served persons eligible for Medicare residing in the 7-town area. From April of 1979 until September 1981 new clients had to be frail elderly at risk of institutionalization and judged able to benefit most from Triage services. Services offered included assessment, case plan development, service monitoring and reimbursement to providers. Starting in August of 1975, the project also obtained waivers of Medicare requirements so that services not usually reimbursed by Medicare could be provided to clients.

Findings:

1. Although project participants spent half as many days in nursing homes as comparison clients because they used home health and hospital services more, overall the costs associated with their care were 70 percent higher than that of the comparison group ($1,617.53 vs. $949.52 respectively). These findings were partially attributed to initially lower hospital usage in the comparison group.

2. Three out of four subgroups of Triage clients had lower mortality rates than comparison clients.

3. Relative to the comparison group, a higher percent of Triage clients showed improved functioning over time.

Source: Joan L. Quinn, Triage II: Coordinated Services to the Elderly, Executive Summary, February 28, 1982.

Project: Wisconsin Community Care Organization: Delivering In-Home Services To The Aged and Disabled (WCCO)

Abstract: WCCO operated in three sites (Milwaukee, La Crosse and Barron) from October 1974 through December of 1979. State funding continues to support project activities for clients served during this time. The target group (persons at risk of institutionalization) was identified by using standards set by a panel of medical and social service professionals in La Crosse County and by scores on the Geriatric Functional Rating Scale (GFRS) in Milwaukee and Barron. In Milwaukee and Barron, participants also had to be Medicaid-eligible and over 65 or over 18 and certified blind/disabled. Services provided included case management including assessment, arranging for delivery of services, contracting for and purchasing services, and monitoring provider performance. The program also obtained a waiver of Medicaid requirements.

Findings:

1. Milwaukee

Even though WCCO clients had lower nursing home, hospital, home health, drug and outpatient medical costs, their overall Medicaid costs (including costs for services provided under the waiver) were $4.62 more a month than those of a randomly assigned control group. When clients who were randomly assigned to the treatment group but did not actually receive treatment were excluded from the analysis, the overall Medicaid costs for CCO clients were $37.22 per month greater than that of experimentals.

In Milwaukee the project did not appear to affect the rate of nursing home institutionalization but Milwaukee WCCO clients spent 8.5 fewer days in nursing homes and 11.3 fewer days in hospitals than controls.

2. La Crosse

Even though the La Crosse WCCO clients had (0.5) fewer hospital and (6.9) fewer nursing home days, Medicaid costs for La Crosse WCCO clients were $40 a month greater than that of comparison clients in Eau Claire. The greater cost was assumed to be due to a higher cost of care in La Crosse vs. Eau Claire County.

3. Overall Findings

The three projects did not demonstrate any improvement in the quality of life of clients over the course of the project or any impact on the numbers of patients in nursing homes.

Source: Fredrick W. Seidl, et. al. Delivering In-Home Services To The Aged and Disabled: The Wisconsin Community Care Organization, University of Wisconsin Faye Mc Beath Institute on Aging and Adult Life, April 1980,
and
Robert Applebaum, et. al. "The Wisconsin Community Care Organization, Preliminary Findings from the Milwaukee Experiment," Evaluation Studies Review Annual, Vol. 6, 1981.

APPENDIX D

Level of Care Definitions SNF

Skilled Nursing and Rehabilitation Services

Federal
Definition: Skilled nursing and/or skilled rehabilitation services are those services furnished pursuant to physicians' orders which:

(1) Require the skills of technical or professional personnel, e.g., (requires 24 hours per day licensed nursing service) registered nurse, licensed practical (vocational) nurse, physical therapist, occupational therapist, speech pathologist, audiologist, and

(2) Are provided either directly by or under the supervision of such personnel.

Changes Noted in the Definition:

1. And/or skilled rehabilitation services: (at least 5 days a week) daily skilled rehabilitation services essential to recovery from inpatient hospital stay or to prevent condition from worsening and which should as a practical matter be provided in an institution.
2. Under the revised definition, an aide could perform skilled services under the general, rather than direct supervision of a licensed nurse (RN or LPN); i.e., at the time of such services, the nurse must only be on the premises of the institution.
3. If a patient needs a variety of unskilled services on a regular daily basis, the patient could be considered a skilled care patient if the planning and overseeing of the unskilled services requires daily skilled assessment and management to meet his needs, promote his recovery, andor actuate his medical safety.

Determination of Services as Skilled:
The following criteria shall apply:

(1) The service would constitute a skilled service where the inherent complexity of a service prescribed for a patient is such that it can be safely and/or effectively performed only by or under the supervision of technical or professional personnel.

(2) The restoration potential of a patient is not the deciding factor in determining whether a service is to be considered skilled or nonskilled. Even where full recovery or medical improvement is not possible, skilled care may be needed to prevent, to the extent possible, deterioration of the condition or to sustain current capacities. (e.g., a terminal cancer patient may require skilled services as defined in the following paragraphs.)

(3) A service that is generally nonskilled would be considered skilled where, because of special medical complications, its performance or supervision or the observation of the patient necessitates the use of skilled nursing or skilled rehabilitation personnel.

For Example: The existence of a plaster cast on an extremity generally does not indicate a need for skilled care, but a patient with a pre-existing acute skin problem or a need for special traction of the injured extremity might need to have technical or professional personnel to properly adjust traction or observe him for complications.

The complications and special services involved must be documented by:

(a) physician's orders
(b) nursing and/or therapy notes

Skilled Nursing or Rehabilitation Services:

Examples include:

1. Overall Management and Evaluation of a Patient Care Plan. The development, management, and evaluation of a patient care plan based on the physician's orders constitutes skilled services when in terms of the patient's physical or mental condition, the development, management and evaluation necessitates the involvement of technical or professional personnel to meet his needs, promote his recovery and actuate his medical safety. This would include the management of a plan involving only a variety of personal care services where in light of the patient's condition the aggregate of such services necessitates the involvement of technical or professional personnel.

   For Example: An aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fractured femur requires among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his condition or complications resulting from his restricted but increasing mobility.

   Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature of the patient's condition, his age, and his immobility create a high potential for serious complications, such an understanding is essential to assure the patient's recovery and safety. Under these circumstances, the management of such a plan of care would require the skills of a nurse even though the individual services are not skilled.

2. Observation and Assessment of the Patient's Changing Condition. When the patient's condition is such that the skills of the nurse or other technical or professional person are required to identify and evaluate the patient's need for possible modification of treatment and the initiation of additional medical procedures until his condition is stabilized constitutes skilled services.

   For Example: A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medications which serve as indicators for adjusting therapeutic measures.

For Example: Surgical patients transferred from a hospital to an SNF while in the complicated, unstabilized post-operative period, e.g., after hip prosthesis or cataract surgery may need continued close skilled monitoring for post-operative complications and adverse reactions.

For Example: Patients who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, etc., may also require skilled observation and assessment by technical or professional personnel to assure their safety and/or the safety of others, i.e., to observe for indications suicidal or hostile behavior. In such cases, special services required must be documented by physicians' orders and/or nursing or therapy notes.

3. Patient Education Services:
In cases where the use of technical or professional personnel is necessary to teach a patient self-maintenance, such teaching services would constitute skilled services.

For Example: A patient who has had a recent leg amputation and needs skilled rehabilitation services provided by technical or professional personnel to provide gait training and teach prosthesis care.

Likewise, a patient newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the self-administration of insulin, foot care precautions, etc.

Services Which Qualify as Skilled Nursing Services:

1. Intravenous, intramuscular, or subcutaneous injections and hypodermoclyses or intravenous feedings.
2. Levine tube and gastrostomy feedings.
3. Nasopharynegeal and tracheotomy aspiration.
4. Insertion and sterile irrigation and replacement of catheters.
5. Application of dressings involving prescription medications and aseptic techniques.
6. Treatment of extensive decubitus ulcers or other widespread skin disorder.
7. Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress.
8. Initial phases of a regimen involving administration of medical gases.
9. Rehabilitation nursing procedures, including the related teaching and daptive aspects of nursing that are part of active treatment, e.g., the instruction and supervision of bowel and bladder training programs.

Services Which Would Qualify as Skilled Rehabilitation Services:

1. Ongoing assessment of rehabilitation needs and potential: Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders:
2. Therapeutic exercises employed or the condition of the patient, must be performed by or under supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment;
3. Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality;
4. Range of motion exercises which are part of an active treatment of a specific disease state which has resulted in a loss of or restriction of mobility as evidenced by the therapist's notes showing the degree of motion lost and the degree to be restored.
5. Maintenance therapy: Maintenance therapy, when the specialized knowledge and judgement of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance.
6. Ultrasound, short-wave, and micro-wave therapy treatments by a qualified physical therapist.
7. Hot packs, hydrocollator, infra-red treatments, paraffin baths, and whirlpool in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures or other complications, and the skills, knowledge and judgement of a qualified physical therapist are required.
8. Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

Intermediate Nursing Care

Interpretation:

Intermediate nursing care means basic care including, physical, emotional, social and other restorative services under periodic medical supervision. This nursing care requires the skill of the registered nurse in administration, including observation and recording of reactions and symptoms, and supervision of nursing care. Most of the patients have long-term illnesses or disabilities which may have reached a relatively stable plateau. Other patients whose conditions are stabilized may need medical and nursing services to maintain stability. Essential supportive consultant services are provided.

Components:

The following services characterize basic nursing care:
Observations of a routine which can be accomplished on general nursing rounds or while procedures such as temperature, pulse and respiration are being done. Relatively simple routine medications and/or simple treatments and/or occasional prn medications or treatments.
Necessary physical care, such as giving baths or assisting with or supervising baths, oral hygiene, etc. This care should be restorative in nature with the goal of fostering independence in activities of daily living.
Limited or occasional special tests.
Frequent and sometimes continuous emotional support in connection with moderately severe or periodic emotional disturbances as guided by a care plan that reflects meaningful follow-through.
Teaching and/or supervised practice as a necessary part of restorative care.
Range of motion exercises as part of routine maintenance and restorative nursing care.
Assisting patients to participate in prescribed individual and group activities.
Administration of topical, oral and selected injectable medications.
Administration of oxygen on an emergency or short-term basis.
Administration of prescribed treatments, such as catheterizations, irrigations and application of dressings and bandages.
Routine care of patients with casts, braces, splints or other appliances requiring nursing care or supervision.
Use of protective restraints, bedrails, binders and supports as ordered by a physician and in accordance with written patient care policies and
Arrangements for obtaining clinical, laboratory, x-ray or other diagnostic services.

Illustrative Services:

The following services are illustrative of the level of intensity of basic nursing care:
Proper positioning of patients in bed, wheelchair or other accommodation.
Bed baths.
Prevention and treatment of skin irritations and decubiti.
Observation of vital signs and detailed recordings of findings in patient record.
Assistance and training in self-care as required for feeding, grooming, ambulation, toilet activities and other activities of daily living.
Assistance and training in patient transfer techniques.

Definition, Components, Illustrative Services for Limited Nursing Care

Definition:

Limited nursing care is defined as simple nursing care procedures required by patients with long-term illnesses or uncomplicated disabilities in order to maintain stability and which can be provided safely only by or under the supervision of a person no less skilled than a licensed practical nurse who shall be under the direction of a registered nurse. Supervision of the physical, emotional, social and restorative needs of the patient shall be under the appropriate medical and/or a paramedical disciplines under the supervision of a physician.

Components:

The following services characterize limited nursing as performed, under supervision, by the licensed practical nurse:

Providing for the emotional and physical comfort and safety of patients.

Responsible for the general health care of patients, assisting with cleanliness, rest, nourishment, and elimination.

Recognition and understanding of the effects of social and economic problems upon patients.

Observing, recording and reporting to the appropriate person patient symptoms reactions and changes which may be indicative of untoward changes.

Performance of simple nursing procedures where a professional degree of evaluative judgment is not required.

Knowledge and application of the principles of the prevention of deformities, in normal range of motion, body mechanics, and body alignment.

Caring for patients where no rapid change is expected in the patient's condition for sometime.

Nursing measures taken do not require modification because of the patient's physical and mental condition.

Illustrative Services:

1. Administration of medications and treatments prescribed by the physicians.

2. Performance of special nursing techniques in caring for patient, i.e., colostomy, incontinence.

3. Prophylactic and palliative skin care including bathing and application of creams and/or treatment of minor skin problems.

4. Routine care in connection with casts, braces, and other devices.

5. Practice of first aid measures.

6. Instructing patients in basic health needs.

7. Change of dressings for noninfected post-operative or chronic conditions.

Personal Care

Interpretation:

Personal care means personal assistance, supervision and a suitable activities program. Provisions are made for periodic medical supervision and other medical services as needed. Such facilities are for individuals who do not need nursing care but do need the services provided by this type of facility in meeting their needs. Examples of such individuals are referrals from institutions for the mentally handicapped; those disabled from aging; the chronically ill whose conditions have become stabilized.

Component:

The services provided are chiefly characterized by the fact that they can be provided by personnel other than those trained in medical or allied fields. The services are directed toward personal care, supervision and protection. The medical service emphasized a preventive approach of periodic medical supervision by the patient physician as part of a formal medical program that will provide required consultation services and also cover emergencies. The dietary needs of patients are met by the provision of an adequate general diet or by therapeutic, medically prescribed diets.
Activity programs, embracing a wide variety of activities to meet individual needs, receive a major emphasis.

Illustrative Services:

The following services are illustrative of personal care:
Assistance with activities of daily living, such as bathing, dressing and eating.
Administration of simple medications.
Supervision of a patient on a prescribed diet.
Taking the patient to his physician for necessary professional services.
Assisting the patient to procure necessary therapeutic and diagnostic treatments on an outpatient basis.
Assisting the patient to participate in prescribed individual group activities.

Residential Care

Interpretation:

Residential care provides social service and activity therapy services for residents with these needs as distinguished from nursing needs. The residents are at least 18 years of age or the residents are aged (generally over 65).

The residents admitted or retained are at least independently mobile. When a resident needs assistance in dressing, bathing, eating or abmulation, he is required to be transferred to at least a personal care nursing home. [Replaced with community-based residential facility definition. These residents require 7 hours or less/week of supportive home care services or personal care services or a combination of both.

APPENDIX E

Community Services Definitions

I. SOCIAL AND ECONOMIC SUPPORT

Goal: Promotion and maintenance of social and economic self-sufficiency through the provision of services in a natural living or supportive service setting, and/or through the network of naturally existing relationships present in the person's community.

1.1 Child Day Care

The provision of services in a child's own home, the home of another, or a day center, for part of a day, to facilitate the child's social, physical cognitive, and emotional growth in the absence of the regular caregiver. Services, which are based upon the needs of children to be served, may include, but are not limited to: education/training; personal care; and supervision. Management functions which may be performed include, but are not limited to: resource recruitment and development; and regulation/certification. Includes the provision of food. While this program is not primarily oriented toward the needs of handicapped children, special provisions may permit some handicapped children to participate. Part-day programs created expressly for the purpose of serving handicapped children, however, should be classified as "Day Services/Treatment."

1.2 Adult Day Care

The provision of services on a voluntary basis in an appropriately certified natural or supportive service setting to adults who need an enriched social experience while receiving protection and supervision during part of the day to remain in a natural living setting. Typical services directed at providing care and protection during part of the day may include: personal care, supervision, and transportation. Benefits include the provision of food. Management functions which may be performed include, but are not limited to: resource recruitment and development, and regulation/certification. Adult developmental services are classified within the Day Services/Treatment program. Includes such activities when provided in a senior center.

1.3 Respite

The provision of services which facilitate or make possible the care of dependents thereby relieving the usual caregiver of stress resulting from the giving of continuous support and/or care to dependent individuals. Services, which are based upon the needs of both the regular caregiver and the dependent person and which are intended to prevent individual and family breakdown or institutionalization generally include assessment/diagnosis; case planning, monitoring, and review; referral; and education/training. Includes assessing the need for respite, arranging for needed resources for the dependent person to enable respite to occur, advising the regular caregiver about the nature of services available and about the specific arrangements for dependent care, and any teaching of respite care workers by regular caregivers. Excludes actual care of the dependent person which should be classified under another appropriate standard program. Also excludes treatment of the regular caregiver to alleviate or reduce stress (to be classified to a treatment-oriented program such as Counseling/ Therapeutic Resources or Day Services/Treatment).

1.4 Supportive Home Care

The provision of services to maintain persons in independent or supervised living in their own home. Services, which are based upon the needs of the person(s) to be served, may include, but are not limited to: household care, personal care, supervision, and education and training. Includes supervised apartment living when there are no live-in staff, senior companion activities; telephone reassurance, friendly visiting, home health care, and home and financial management activities (including 24 hour in-home child care). Includes payments to maintain an individual in the independent living arrangement in which the supervision is occurring. Counseling/Psychotherapy in a person's own home is part of the Counseling/Therapeutic Resources program.

1.5 Housing Assistance

The provision of services in a natural or supportive service setting which enable persons living in substandard housing to obtain safe, healthful, and affordable housing. Services, which are based upon the needs of persons to be served, may include, but are not limited to: advocacy; assessment/diagnosis, education and training, and referral. Includes working with landlords and others to upgrade sub-standard housing, assessing housing needs, locating appropriate housing, referral to existing resources for housing repairs, and making arrangements for moving (as well as payment of moving expenses). Excludes: repairs and remodeling, winterization/weatherization, addition of ramps or other special modifications or equipment for handicapped persons, and the costs of fuel or utilities. All of the latter exclusions are part of the Home Modifications/Energy Assistance program. Placement of persons into independent living from alternate living settings is classified as Placement Assistance and Monitoring.

1.6 Home Modification/Energy Assistance

The provision of the material benefits required to enable persons to obtain, or remain in safe, healthful and affordable housing. Includes all material benefits necessary for: repairs to meet minimum housing standards; construction of ramps or other special modifications or equipment for handicapped persons; weatherization/winterization; and the costs of full utilities. Unskilled routine home maintenance tasks are part of the Supportive Home Care program.

1.7 Specialized Transportation & Escort

The provision of transportation and transportation-related supervision on a voluntary basis to the elderly, handicapped, or other persons with limited ability to access needed resources. Includes provision of material benefits such as tickets or cash for their purchase as well as specially-equipped vehicles designed to provide safe, comfortable, and accessible conveyance. Transportation when provided as part of another program is not included here.

1.8 Work-Related Services

The provision of services for purposes of providing employment, employment opportunities and/or removing obstacles to gainful employment. Services, which are based upon the needs of persons to be served, may include, but are not limited to: education/training, work-related transportation; marketing of products; assessment/diagnosis; case planning, monitoring and review; and supervision. Management functions which may be performed include, but are not limited to: resource recruitment and development (e.g. job development) and contracting. Cash benefits in the form of wages (e.g., sheltered work) or items needed for employment are also included. Includes sheltered employment, work activities, CETA, work relief, displaced homemaker's services.

II. ALTERNATE LIVING

Goal: Substitute community-based residential living arrangements for the care and protection of individuals not able to live independently or with their natural families.

2.1 Adoptions

The provision of services needed to locate and screen adoptive applicants, match available foster children to adoptive applicants and generally secure permanent, substitute legal parents for children legally free for adoption. Services, which are based upon the needs of persons to be served, may include, but are not limited to: assessment/ diagnosis; case planning, monitoring and review; and supervision in foster homes. Management functions which may be performed include, but are not limited to: resource recruitment and development. Includes the costs of adoption subsidies as well as stepparent, independent, interstate and foreign adoptions activities.

2.2 Adult Family Home

The provision of structure and support to adults whose physical, developmental, and emotional functioning is likely to be maximized in a family type of living arrangement for one or two adults. Services in the family home, which are based upon the needs of persons to be served, may include, but are not limited to: supervision, dietary, personal care, and education/ training. Material benefits include food and housing. Includes recruiting and certifying of adult family homes. Locating, arranging for, and monitoring family home placements is part of the Placement Assistance and Monitoring program.

2.3 Foster Home

The provision of a loving, caring, and supportive substitute family to children. Services provided by foster parents based upon the needs of foster children may include, but are not limited to: supervision, dietary, personal care, and transportation. Material benefits include: food, housing, items, and clothing. Includes recruiting and licensing of foster homes. Locating, arranging for, and monitoring a foster home placement is part of the Placement Assistance and Monitoring program. Activities involving foster homes in which there is a pending adoption (i.e., the foster home is to become an adoptive home) should be classified as part of the Adoptions Program.

2.4 Group Home

The provision of supportive services in the least restrictive community-based group living setting to children for whom a living arrangement with peers or siblings is judged to be most beneficial. Group home services based upon the needs of persons to be served may include, but are not limited to: supervision, dietary, personal care, and transportation. Benefits include: food, housing, items, and clothing. Includes recruiting and licensing of group homes. Locating, arranging for, and monitoring of group home placements by persons other than the group home provider is part of the Placement Assistance and Monitoring Program.

2.5 Shelter Care

The provision of short-term services, often under emergency conditions, in a shelter care facility to persons who need a temporary place to stay pending resolution of problems in their own home. Services, which are based upon the needs of persons to be served may include, but are not limited to: supervision, dietary, and counseling/psychotherapy. Benefits include food and housing. Locating, arranging for, and monitoring placement in shelter care facilities by persons other than the shelter care provider is part of the Placement Assistance and Monitoring Program.

III. SECURITY, REHABILITATION, & REINTEGRATION OF PERSONS INVOLVED WITH THE JUSTICE SYSTEM

Goal: To ameliorate the conditions which are conducive to the development of illegal or dangerous behaviors and which have caused or are likely to cause an individual to be brought to the attention of the justice system.

3.1 Services to the Courts

The provision of services essential to the provision of reports and recommendations to the court. Services, which are based upon the needs of persons to be served, may include, but are not limited to: assessment/ diagnosis; and case planning, monitoring, and review. Includes custody studies persuants to divorce actions. Court-ordered services to individuals are classified primarily under other programs directed at the goal of Security, Rehabilitation, & Reintegration of Persons Involved with the Justice System. (Primary focus is upon court ordered assessments and reports required under Chapters 48, 51, and 55 Wis. Stats.)

3.2 Criminal & Juvenile Justice System Diversion

The provision of services to persons involved in any phase of the criminal or juvenile justice system for purposes of channeling these persons from the criminal or juvenile justice system into the human services delivery system. Services, which are based upon the needs of persons to be served, may include, but are not limited to: assessment/ diagnosis; education/training; case planning, monitoring and review; and counseling/psychotherapy. Includes services in the SPRITE program.

3.3 Probation & Juvenile Supervision Services

The provision of services to probationers and juveniles under county department or court formal or informal "supervision" for purposes of preventing continuing criminal or delinquent activities or other unacceptable behavior brought to the attention of the juvenile justice system. Services, which are based upon the needs of persons to be served, may include, but are not limited to: case planning, monitoring; and review and counseling/psychotherapy. Includes payment of rent in a supervised independent living arrangement. Excludes the provision of an alternate living setting which should be classified under an appropriate alternate living standard program.

3.4 Parole, Mandatory Release & Reintegration Aftercare Services

The provision of services to residents of correctional facilities, parolees, persons on mandatory release, or otherwise released from a correctional facility for purposes of strengthening family ties and aiding transition from institution to community. Services, which are based upon the needs of persons to be served, may include, but are not limited to: case planning, monitoring and review. Excludes the provision of an alternate living setting which should be classified under an appropriate alternate living standard program.

3.5 Court Ordered Obligations

The provision of services on an involuntary basis to persons under court order to make restitution or other court ordered payments or obligations pertaining to attorney's fees, court costs, supervised work, restitution, and victim compensation. Services, which are based upon the needs of persons to be served, may include, but are not limited to: assessment/diagnosis; case planning, monitoring, and review; referral; counseling/psychotherapy; and education/training.

3.6 Juvenile Correctional Institution Services

The provision of services within a secure county juvenile detention facility or within a state juvenile correctional institution to children who are adjudicated delinquents. Services are intended to ensure public safety and must include supervision and dietary. Material benefits include food and housing.

IV. PROMOTE PERSONAL, FAMILY & COMMUNITY WELL-BEING

Goal: Promotion of optimal personal, family, and community well-being including prevention of the development of dysfunctions.

4.1 Congregate Meals

The provision of services to persons in natural or supportive service settings to promote adequate nutrition. Services, which are based upon the needs of persons to be served, may include, but are not limited to: education/training, public information, and case finding. The provision of nutrition education in this program is limited to the congregate meals portion of this program.

4.2 Home Delivered Meals

The provision of meals to persons at risk with regard to adequate nutrition in their own home to maintain or improve adequate nutrition. Services, which are based upon the needs of persons to be served, may include, but are not limited to: case finding and transportation. Provision of food is an essential part of this program.

4.3 Recreation/Alternative Activities

The provision of services on a voluntary basis in a natural or supportive setting to persons who are socially or physically inactive, or whose activities are socially inappropriate, increasing their participation in constructive leisure time activities which enhance their dignity, support their independence, and/or encourage their involvement in and with the community. Services, which are based upon the needs of persons to be served, may include, but are not limited to: supervision, education/training, and transportation. Management functions which may be performed include, but are not limited to: resource recruitment and development related to development of recreational opportunities. Includes physical education or exercises for senior citizens (as well as senior center activities), Big Brothers, camping experiences, YMCA, YWCA, 4-H, special olympics, and other group activities.

4.4 Family Planning

The provision of services to enable persons to voluntarily determine their family size and composition. Services, which are based upon the needs of persons to be served, may include, but are not limited to: education/training, referral, assessment/diagnosis, physical health and laboratory services, and the provision of drugs and items. May include genetic "counseling."

4.5 Preventative Education/Adjustment Skill Building

The provision of services on a voluntary basis in a natural or supportive service setting to persons at risk, to improve their ability to cope with times of social and personal stress. Services, which are based upon the needs of persons to be served, may include, but are not limited to: education/training, and referral. Since the service of

counseling/psychotherapy is directed at persons who already are in need of therapeutic services, this service or other treatment or therapy services are inappropriate for this program.

4.6 Protective Payment

The provision of services to persons who receive a money grant but are unable to use that grant in their own best interests. Services which are to ensure that the intended benefits of a money grant are used in the best interests of the beneficiary, may include, but are not limited to: dietary; and supervision. The costs of guardians is included as part of the Guardianship program. Includes recruitment and development of protective payees as an agency resource.

4.7 Guardianship

The provision of services by court appointed guardians to protect persons who are unable to manage their own affairs. Services provided by guardians may include, but are not limited to: supervision; household care; case planning, monitoring, and review. Management functions include resource recruitment and development. Includes activities required to obtain court appointed guardians. Guardianship activities for purposes of adoption are part of the Adoptions program.

4.8 Community Organization/Public Awareness

The provision of services to the general public in natural or supportive service settings directed at increasing public knowledge about, and responsiveness to, social, personal, and community problems. Services, which are based upon the needs of persons to be served, may include, but are not limited to: advocacy, public information, education/training. Program planning directed at correcting specific community problems is part of this program. Also includes the providing of factual information on the human services system, on disabilities, and on specific community problems and related topics and improve community acceptance of services and persons receiving those services. Includes presentations to various community groups and agencies (e.g. public school students) for purposes of developing increased awareness. Excludes such presentations when their primary function is resource recruitment and development.

V. MAINTAIN AND/OR IMPROVE PERSONAL, PHYSICAL, AND MENTAL HEALTH

Goal: The amelioration or elimination of the effects of illness, injury and other debilitating conditions by intervening to maintain or improve health and functioning.

5.1 Crisis Intervention

The provision of services intended to prepare for and/or remove conditions which are an immediate threat to a person's life or well-being. Services, which are based upon the needs of persons to be served, may include, but are not limited to: counseling/psychotherapy, supervision, general physical health, transportation, and referral. Management functions which may be performed include, but are not limited to: resource recruitment and development; and contracting. Services include 24-hour "hot lines" and extra-hour staffing for handling emergencies. Excludes emergency conditions which are an integral, but subordinate part, of other standard programs. Excludes any emergency inpatient care; the latter is to be classified as part of the Inpatient Program.

5.2 Detoxification

The provision of services to alcohol and drug abusers to withdraw toxic substances from the blood system and supervision of symptoms resulting from this withdrawal in order to ensure adequate health stabilization. Services, which are based upon the needs of persons to be served, may include, but are not limited to: medical support and laboratory services, supervision, referral, personal care, and case planning, monitoring and review. Includes the provision of drugs. Includes beds reserved for social setting detoxification.

5.3 Inpatient

The provision of services in inpatient settings to stabilize and/or ameliorate mental illness (short-term or long-term) alcohol or other drug abuse or other problems requiring hospitalization, enabling persons to function effectively in a less restrictive alternative or a natural living setting. Services restricted to the 24-hour units of an inpatient facility, may include but are not limited to: assessment/ diagnosis; case planning, monitoring, and review, counseling/ psychotherapy; physical health activities; education/ training; personal care; supervision; and therapy. Food and housing are required benefits and drugs are also commonly provided. Includes stays under emergency detention and commitment provisions. Planning for, arranging for, and monitoring of inpatient facilities placements by persons other than facility staff is part of the Placement Assistance and Monitoring Program.

5.4 Child Care Institution

The provision of services to children in child care institutions for purposes of stabilizing and/or ameliorating of behavioral disorders enabling them to return to their own communities in the shortest

possible time. Services, which are based upon the needs of persons to be served, may include, but are not limited to: supervision, education/training, and counseling/psychotherapy. Benefits include food, housing, and items-such as school supplies and books. Planning for, arranging for, and monitoring of child care institution placements by persons other than CCI staff is part of the Placement Assistance and Monitoring program.

5.5 D.D. Center

The provision of services at Wisconsin's three Developmental Disability Centers to reduce the severity of behavioral or medical problems which attend and complicate severe developmental disabilities. Services, which are based upon the needs of persons to be served, may include, but are not limited to: assessment/diagnosis, physical health services, surgical services, therapy and laboratory services, personal care, supervision. Benefits include food, items, housing, and drugs. Management functions which may be performed include, but are not limited to research. The services and resources provided are generally unavailable outside of the DD Centers due to the nature and severity of problems involved. Planning for, arranging for, and monitoring of DD Center placements by non-DD Center staff is part of the Placement Assistance and Monitoring program.

5.6 Community-Based Care/Treatment Facility

The provision of services in a CBRF for purposes of providing needed care or support and/or ameliorating personal, social and/or behavioral dysfunctions. Services, which are based upon the needs of persons to be served, may include, but are not limited to: supervision, dietary, counseling/psychotherapy. Benefits include food and housing. Planning for, arranging for, and monitoring of placements in these facilities by persons other than facility staff is part of the Placement Assistance and Monitoring program. Services to persons involved in any stage of the criminal justice system are classified to a program under HST Goal 3.

5.7 Counseling/Therapeutic Resources

The provision of treatment-oriented services in settings other than alternate living or day centers to persons needing treatment to maintain or improve effective functioning. Services, which are based upon the needs of persons to be served, may include, but are not limited to: assessment/diagnosis, counseling/psychotherapy, therapy services, physical health services and medical support services. Includes divorce and family counseling and counseling for students experiencing behavioral problems at school. Services to persons involved in any stage of the criminal or juvenile justice system are classified within a program under that goal. Includes methadone maintenance activities. Excludes work-related services.

5.8 Day Service/Treatment

The provision of services in day centers to juveniles adjudicated delinquent and persons with physical, developmental, chemical abuse or mental problems to enhance maturation and social development and reduce the extent and effects of disabilities. Services, which are based upon the needs of persons to be served, may include, but are not limited to: assessment/diagnosis, transportation to the setting, education/ training, counseling/psychotherapy, supervision, and personal care. Includes preschool developmental activities. Activities formerly considered to be day treatment and day services (medical and non-medical) program elements by the "51 system" are now encompassed in this standard program. Excludes work-related services.

5.9 Community Support

The provision of services in a natural or supportive services setting to adults with chronic substance abuse problems or long-term mental, physical, emotional or developmental disabilities that seriously limit their functional capacities relative to primary aspects of daily living without which 24-hour facility based care would be necessary. Services which are focused on achieving optimal functioning through on-going assertive support may include, but are not limited to: assessment/diagnosis; education/training; physical health services; case planning, monitoring, and review; advocacy; and case finding.

VI. SYSTEM ACCESS

Goal: Identify the need for, and improve the availability of, services which meet human needs.

6.1 Outreach

The provision of services in a natural or supportive service setting directed at locating persons likely to have, or to develop, a problem which can potentially be alleviated by the delivery of human services; and linkage to an intake assessment process. Services, which are based upon the needs of persons to be served, may include, but are not limited to: casefinding, eligibility determination, and referral. Includes Employee Assistance and Student Assistance activities. Includes establishment of referral networks.

6.2 Information and Referral

The provision of public information and referral services to satisfy individual inquiries for specific information about a particular aspect of the human service delivery system or community resources and ensure linkage to needed resources. Includes referral to legal resources; excludes public information and referral when provided for family planning or as a subordinate part of an intake process (i.e. Intake Assessment program). Includes information administration as a management function (i.e. maintaining and summarizing records of information and referral contacts).

6.3 Intake Assessment

The provision of services in a supportive service setting to persons who are referred and/or apply for services to determine the existence of, and the nature of, a specific problem or group of problems. Services, which are based upon the needs of persons to be served, may include, but are not limited to: assessment/diagnosis and referral. Investigations or assessments for the court are part of the Services to the Courts Program. Assessment/diagnosis which is an integral, but subordinate part of another specific program should be classified to that program.

6.4 Case Management/Service Coordination

The provision of services in a supportive service setting to enable human service recipients to receive a full range of appropriate services in a planned, coordinated, efficient and effective manner. Services, which are based upon the needs of persons to be served, may include, but are not limited to: case planning, monitoring and review; advocacy; assessment/diagnosis; and referral. This program is a natural outgrowth of the Intake Assessment program and begins where the latter ends for persons who will be receiving human services. Services that are typical for this program may be an integral, but subordinate part of other programs, when the client is receiving services in only one program. Planning for, arranging for, or monitoring a change in residential setting (i.e. where the client is living) is to be classifed as either Placement Assistance and Monitoring, or Housing Assistance.

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6.5 Legal and Defense Resources

The provision of services for purposes of rights to fair and just treatment. Services, which may be provided by lay advocates as well as persons with legal training and which are based upon the needs of persons to be served, may include, but are not limited to: education/training, and advocacy. Includes assistance in applying for needed services or benefits, assistance in the use of appropriate grievance procedures, provision of representation for clients at hearings, the provision of legal advice, legal representation in court, legal research, education and counseling regarding legal rights and responsibilities, and interpreters to protect the rights of the hearing impaired to fair and just treatment. Referral to legal resources is part of the Information and Referral Program unless it is part of a generalized intake process, in which case it is part of the Intake Assessment Program.

6.6 Health Screening and Accessibility

The provision of services in a natural or supportive service setting to persons at risk for health problems for the purpose of early identification of persons with health care needs and improved accessibility to needed health care services. Services, which are based upon the needs of persons to be served, may include, but are not limited to: case finding; assessment/diagnosis; case planning, monitoring and review; referral; and advocacy.

6.7 Placement Assistance and Monitoring

The provision of services for purposes of obtaining and/or maintinaing placements of individuals in the most appropriate, least restrictive approved or licensed alternate living setting or returning them to their own home. Services, which are based upon the needs of persons to be served, may include, but are not limited to: assessment/diagnosis; case planning, monitoring and review; and transportation to the placement setting. Includes permanency planning activities as well as activities related to the termination of parental rights and the selection of an appropriate placement setting. Excludes adoptions activities and activities performed by staff of alternate living settings.

VII. COMMUNITY SERVICES MANAGEMENT

Goal: Improve the means by which, and the conditions under which, human services are delivered.

7.1 Manpower Training and Development

Management functions in a natural or supportive service setting directed at maximizing the knowledge and skills of individual human services providers. Management functions which may be performed include, but are not limited to: personnel development and consultation/training.

7.2 Agency/Systems Management

Management functions which are directed at the creation of an effective, efficient, accountable, and accessible service delivery system. Excludes management functions associated directly with any program or other management category shown above.